pt. 11/989

Medicare

State Medicaid Manual

Part 11 - Medicaid Management Information System

U.S. Department of
Health and Human Services
Health Care Financing Administration
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PART 11

STATE MEDICAID MANUAL

(SMM)

MEDICAID MANAGEMENT INFORMATION SYSTEM

(MMIS)

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CHECK SHEET OF STATE MEDICAID MANUAL REVISION TRANSMITTALS - PART 11

This check sheet should be placed at the front of the Part 11 section of the manual to provide a record of manual revisions.

01. 7/81 ~~7-24-81~~	21.	41.	61.	81.
02. 2/82	22.	42.	62.	82.
03. 9/85	23.	43.	63.	83.
04. 2/85	24.	44.	64.	84.
05. 4/85	25.	45.	65.	85.
06. 7/18/85	26.	46.	66.	86.
07. 12/17/85	27.	47.	67.	87.
08. 7/86	28.	48.	68.	88.
09. 8/87	29.	49.	69.	89.
10. 4/89	30.	50.	70.	90.
11.	31.	51.	71.	91.
12.	32.	52.	72.	92.
13.	33.	53.	73.	93.
14.	34.	54.	74.	94.
15.	35.	55.	75.	95.
16.	36.	56.	76.	96.
17.	37.	57.	77.	97.
18.	38.	58.	78.	98.
19.	39.	59.	79.	99.
20.	40.	60.	80.	100.

101. _____	121. _____	141. _____	161. _____	181. _____
102. _____	122. _____	142. _____	162. _____	182. _____
103. _____	123. _____	143. _____	163. _____	183. _____
104. _____	124. _____	144. _____	164. _____	184. _____
105. _____	125. _____	145. _____	165. _____	185. _____
106. _____	126. _____	146. _____	166. _____	186. _____
107. _____	127. _____	147. _____	167. _____	187. _____
108. _____	128. _____	148. _____	168. _____	188. _____
109. _____	129. _____	149. _____	169. _____	189. _____
110. _____	130. _____	150. _____	170. _____	190. _____
111. _____	131. _____	151. _____	171. _____	191. _____
112. _____	132. _____	152. _____	172. _____	192. _____
113. _____	133. _____	153. _____	173. _____	193. _____
114. _____	134. _____	154. _____	174. _____	194. _____
115. _____	135. _____	155. _____	175. _____	195. _____
116. _____	136. _____	156. _____	176. _____	196. _____
117. _____	137. _____	157. _____	177. _____	197. _____
118. _____	138. _____	158. _____	178. _____	198. _____
119. _____	139. _____	159. _____	179. _____	199. _____
120. _____	140. _____	160. _____	180. _____	200. _____

201. _____
202. _____
203. _____
204. _____
205. _____
206. _____
207. _____
208. _____
209. _____
210. _____
211. _____
212. _____
213. _____
214. _____
215. _____
216. _____
217. _____
218. _____
219. _____
220. _____

221. _____
222. _____
223. _____
224. _____
225. _____
226. _____
227. _____
228. _____
229. _____
230. _____
231. _____
232. _____
233. _____
234. _____
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270. _____
271. _____
272. _____
273. _____
274. _____
275. _____
276. _____
277. _____
278. _____
279. _____
280. _____

281. _____
282. _____
283. _____
284. _____
285. _____
286. _____
287. _____
288. _____
289. _____
290. _____
291. _____
292. _____
293. _____
294. _____
295. _____
296. _____
297. _____
298. _____
299. _____
300. _____

TABLE OF CONTENTS

		PAGE	SECTION
CHAPTER 1	GENERAL	11-1-1	11100
CHAPTER 2	APPROVAL OF MMIS SYSTEMS	11-2-1	11200
CHAPTER 3	SYSTEM REQUIREMENTS	11-3-1	11300
CHAPTER 4	SYSTEMS PERFORMANCE REQUIREMENTS	11-4-1	11400
CHAPTER 5	RESERVED		
CHAPTER 6	CLAIMS PROCESSING ASSESSMENT SYSTEM REVIEW PROCESS	11-6-1	11600

LEGAL BACKGROUND AND AUTHORITY

Title XIX of the Social Security Act, specifically Section 1903(a)(3) as provided by Section 235 of Public Law 92-603, enacted October 30, 1972, and amended by Section 10 of Public Law 95-142, enacted October 25, 1977 and Section 1903(r) as provided by Section 901 of Public Law 96-398, enacted October 7, 1980, and amended by section 9503 (b) of Public Law 99-272, enacted April 7, 1986.

TITLE XIX--GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

Payment to States

Sec. 1903(a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966 -

(3) an amount equal to

(A)

(i) 90 percentum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of Title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title, and

(B) 75 percentum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; plus 1/

(C) 75 percentum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of medical and utilization review by a Utilization Review and Quality Control Peer Review Organization under a contract entered into under 1902(d); plus 2/

1/ Subparagraph (B) was amended by sec. 10 of P.L. 95-142.

2/ Subparagraph (C) was added by 1981 OBRA and amended by PL 97-248 1982 TEFRA

TITLE IX - MECHANIZED CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

MECHANIZED CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

Section 1903 of the Social Security Act was amended, by Public Law 96-398, section 901, by adding the following new subsection:

(r)

(1)

(A) In order to receive payments under paragraphs (2) and (7) of subsection (a) without being subject to percentum reductions set forth in subparagraph (C) of this paragraph, a State must provide that mechanized claims processing and information retrieval systems of the type described in subsection (a)(3)(B) and detailed in an advance planning document approved by the Secretary are operational on or before the deadline established under subparagraph (B).

(B) The deadline for operation of such systems for a State is September 30, 1985.

(C) If a State fails to meet the deadline established under subparagraph (B), the percentums specified in paragraphs (2) and (7) of subsection (a) with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning on or after such deadline, and shall be further reduced by an additional 5 percentage points after each period consisting of two quarters during which the Secretary determines the State fails to meet the requirements of subparagraph (A); except that --

(i) neither such percentum may be reduced by more than 25 percentage points by reason of this paragraph; and

(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State meets the requirements of subparagraph (A).

(2)

(A) In order to receive payments under paragraphs (2) and (7) of subsection (a) without being subject to the percentum reductions set forth in subparagraph (C) of this paragraph, a State must have its mechanized claims processing and information retrieval systems, of the type required to be operational under paragraph (1), initially approved by the Secretary in accordance with paragraph (5)(A) on or before the deadline established under subparagraph (B).

(B) The deadline for approval of such systems for a State is the last day of the fourth quarter that begins after the date on which the Secretary determines that such systems became operational as required under paragraph (1).

(C) If a State fails to meet the deadline established under subparagraph (B), the percentum specified in paragraphs (2) and (7) of subsection (a) with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning after such deadline, and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters during which the State fails to meet the requirements of subparagraph (A); except that --

(i) neither such percentum may be reduced by more than 25 percentage points by reason of this paragraph; and

(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State's systems are approved by the Secretary as provided in subparagraph (A).

(D) Any State's systems which are approved by the Secretary for purposes of subsection (a)(3)(B) on or before the date of the enactment of this subsection shall be deemed to be initially approved for purposes of this subsection.

(3)

(A) When a State's systems are initially approved, the 75 percentum Federal matching provided in subsection (a)(3)(B) shall become effective with respect to such systems, retroactive to the first quarter beginning after the date on which such systems became operational as required under paragraph (1), except as provided in subparagraph (B).

(B) In the case of any State which was subject to a percentum reduction under paragraph (2), the percentum specified in subsection (a)(3)(B) shall be reduced by 5 percentage points for the first two quarters beginning after the deadline established under paragraph (2)(B), and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters beginning after such deadline and before the date on which such systems are initially approved, except that no reduction shall be made under this paragraph for any quarter following the quarter during which the State's systems are initially approved by the Secretary.

(4)

(A) The Secretary shall review all approved systems not less often than once every three years, and shall reapprove or disapprove any such systems. Systems which fail to meet the current performance standards, system requirements, and any other conditions for approval developed by

the Secretary under paragraph (6) shall be disapproved. Any State having systems which are so disapproved shall be subject to a percentum reduction under subparagraph (B). The Secretary shall make the determination of reapproval or disapproval and so notify the States not later than the end of the first quarter following the review period. Reviews may, at the Secretary's discretion, constitute reviews of the entire system or of only those standards, system requirements, and other conditions which have demonstrated weakness in previous reviews.

(B) If the Secretary disapproves a State's systems under subparagraph (A), the Secretary shall, with respect to such State for quarters beginning after the determination of disapproval and before the first quarter beginning after such systems are reapproved, reduce the percentum specified in subsection (a)(3)(B) to a percentum of not less than 50 percentum and not more than 70 percentum as the Secretary determines to be appropriate and commensurate with the nature of noncompliance by such State; except that such percentum may not be reduced by more than 10 percentage points in any four quarter period by reason of this subparagraph. No State shall be subject to a percentum reduction under this paragraph (i) before the fifth quarter beginning after such State's systems were initially approved, or (ii) on the basis of a review conducted before October 1, 1981.

(C) The Secretary may retroactively waive a percentum reduction imposed under subparagraph (B), if the Secretary determines that the State's systems meet all current performance standards and other requirements for reapproval and that such action would improve the administration of the State's plan under this title, except that no such waiver may extend beyond the four quarters immediately prior to the quarter in which the State's systems are reapproved.

(5)

(A) In order to be initially approved by the Secretary, mechanized claims processing and information retrieval systems must be of type described in subsection (a)(3)(B) and must meet the following requirements:

(i) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

(ii) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's Medicaid fraud control unit (if any) certified under subsection (q) of this section.

(iii) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary under paragraph (6).

(B) In order to be reapproved by the Secretary, mechanized claims processing and information retrieval systems must meet the requirements of subparagraphs (A)(i) and (A)(ii) and performance standards and other requirements for reapproval developed by the Secretary under paragraph (6).

(6) The Secretary, with respect to State systems, shall --

(A) develop performance standards, system requirements, and other conditions for approval for use in initially approving such State systems, and shall further develop written approval procedures for conducting reviews for initial approval, including specific criteria for assessing systems in operation to insure that all such performance standards and other requirements are met;

(B) by not later than October 1, 1980, develop an initial set of performance standards, system requirements, and other conditions for reapproval for use in reapproving or disapproving State systems, and shall further develop written reapproval procedures for conducting reviews for reapproval, including specific criteria for reassessing systems operations over a period of at least six months during each fiscal year to insure that all such performance standards and other requirements are met on a continuous basis;

(C) provide that reviews for reapproval, conducted before October 1, 1981, shall be for the purpose of developing a systems performance data base and assisting States to improve their systems, and that no percentum reduction shall be made under paragraph (4) on the basis of such a review;

(D) insure that review procedures, performance standards, and other requirements developed under subparagraph (B) are sufficiently flexible to allow for differing administrative needs among the States, and that such procedures, standards, and requirements are of a nature which will permit their use by the States for self-evaluation;

(E) notify all States of proposed procedures, standards, and other requirements at least one quarter prior to the fiscal year in which such procedures, standards, and other requirements will be used for conducting reviews for reapproval;

(F) periodically update the systems performance standards, system requirements, review criteria, objectives, regulations, and guides as the Secretary shall from time-to-time deem appropriate;

(G) provide technical assistance to States in the development and improvement of the systems so as to continually improve the capacity of such systems to effectively detect cases of fraud or abuse;

(H) for the purpose of insuring compatibility between the State systems and the systems utilized in the administration of title XVIII --

(i) develop a uniform identification coding system (to the extent feasible) for providers, other persons receiving payments under the State plans (approved under this title) or under title XVIII, and beneficiaries of medical services under such plans or title;

(ii) provide liaison between States and carriers and intermediaries having agreements under title XVIII to facilitate timely exchange of appropriate data; and

(iii) improve the exchange of data between the States and the Secretary with respect to providers and other persons who have been terminated, suspended, or otherwise sanctioned under a State plan (approved under this title) or under title XVIII.

(I) develop and disseminate clear definitions of those types of reasonable costs relating to State systems which are reimbursable under the provisions of subsection (a)(3) of this section; and

(J) develop and disseminate performance standards for assessing the State's third party collection efforts in accoradance with section 1902(a)(25)(A)(ii).

(7)

(A) The Secretary shall waive the provisions of this subsection with respect to initial operation and approval of mechanized claims processing and information retrieval systems with respect to any State which --

(i) had a 1976 population (as reported by the Bureau of the Census) of less than 1,000,000 and which made total expenditures (including Federal reimbursement) for which Federal financial participation is authorized under this title of less than $100,000,000 in fiscal year 1976 (as reported by such State for such year), or

(ii) is a Commonwealth, or territory or possession, of the United States, if such State reasonably demonstrates, and the Secretary does not formally disagree, that the application of such provisions would not significantly improve the efficiency of the administration of such State's plan under this title.

(B) If the Secretary determines that the application of the provisions described in subparagraph (A) to a State would significantly improve the efficiency of the administration of the State's plan under this title, the Secretary may withdraw the State's waiver under subparagraph (A) and, in such case, the Secretary shall impose a timetable for such State with respect to compliance with the provisions of this subsection and the imposition of percentum reductions. Such timetable shall be comparable to the timetable established under this subsection as to the amount of time allowed such State to comply and the timing of percentum reductions.

(8)

(A) The percentum reductions provided for under this subsection shall not apply to a State for any quarter with respect to which the Secretary determines that such State is unable to comply with the relevant requirements of this subsection --

(i) for good cause (but such a waiver may not be for a period in excess of two quarters), or

(ii) due to circumstances beyond the control of such State

(B) If the Secretary determines under subparagraph (A) that such a reduction will not apply to a State, the Secretary shall report to the Congress on the basis for each such determination and on the modification of all time limitations and deadlines as described in subparagraph (C).

(C) For purposes of determining all time limitations and deadlines imposed under this subsection, any time period during which a State was found under subparagraph (A)(ii) to be unable to comply with requirements of this subsection due to circumstances beyond its control shall not be taken into account, and the Secretary shall modify all such time limitations and deadlines with respect to such State accordingly."

CITATION OF REGULATION

Subpart C - Mechanized Claims Processing and Information Retrieval Systems

Section 433.110 Basis and Purpose.

(a) This subpart implements the following sections of the Act:

(1) Section 1903(a)(3) of the Act, which provides for FFP in State expenditures for the design, development, or installation of mechanized claims processing and information retrieval systems and for the operation of certain systems. Additional HHS regulations and HCFA procedures for implementing these regulations are in 45 CFR Part 74, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

(2) Section 1903(r) of the Act, which--

(i) Requires reductions in FFP otherwise due a State under section 1903(a) if a State fails to meet certain deadlines for operating a mechanized claims processing and information retrieval system or if the system fails to meet certain conditions of approval or conditions of reapproval;

(ii) Requires at least an annual Federal performance review of the mechanized claims processing and information retrieval systems; and

(iii) Allows waivers of conditions of approval, conditions of reapproval, and FFP reductions under certain circumstances.

(b) The requirements under section 1903(r) of the Act do not apply to Puerto Rico, Guam, the Virgin Islands, American Samoa and the Northern Mariana Islands.

Section 433.111 Definitions.

For purposes of this section:

"Advance Planning Document (APD)" means a written plan of action to acquire the proposed system. Content requirements for the APD are in 45 CFR Part 95, Subpart F, and in Part 11 of the State Medicaid Manual (SMM).

"Design" or "system design" means the putting together of new or more efficient automatic data processing system. This includes the use of hardware to the extent necessary for the design phase.

"Development" means the definition of system requirements, detailing of system and program specifications, programming, and testing. This includes the use of hardware to the extent necessary for the development phase.

"Hardware" means automatic equipment used for a mechanized claims processing and information retrieval system. This equipment accepts and stores data, performs calculations and other processing steps, and produces information. Hardware includes:

(1) Electronic digital computers;
(2) Peripheral or auxilary equipment used in support of electronic computers;
(3) Data transmission or communications equipment; and
(4) Data input equipment.

"Improvement" means modification of or addition to an existing operational mechanized claims processing and information retrieval system, which benefits the efficient, economical or effective administration of the State plan.

"Installation" means the integrated testing of programs and subsystems, system conversion, and turnover to operational status. This includes the use of hardware to the extent necessary for the installation phase.

"Mechanized claims processing and information retrieval system" means a system of software and hardware used to process Medicaid claims, and to retrieve and produce utilization and management information about services that is required by the Medicaid agency or Federal Government for administrative and audit purposes.

"Operation" means the automated processing of claims, payments, and reports. "Operation" includes the use of supplies, software, hardware, and personnel directly associated with the functioning of the mechanized system.

"Software" means computer programs, procedures, and associated documentation used to operate the hardware.

Section 433.112 FFP for design, development, installation or improvement of mechanized claims processing and information retrieval systems.

(a) FFP is available at the 90 percent rate in State expenditures for design, development, installation or improvement of a mechanized claims processing and information retrieval system only if the APD is approved by HCFA prior to the State's expenditure of funds for these purposes.

(b) HCFA will approve the system described in the APD if the following conditions are met:

(1) HCFA determines the system is likely to provide more efficient, economical, and effective administration of the State plan.

(2) The system meets the system requirements and performance standards in Part 11 of the State Medicaid Manual, as periodically amended.

(3) The system is compatible with the claims processing and information retrieval systems used in the administration of Medicare for prompt eligibility verification and for processing claims for persons eligible for both programs.

(4) The system supports the data requirements of peer review organizations established under part B of Title XI of the Act.

(5) The State owns any software that is designed, developed, installed or improved with 90 percent FFP.

(6) The Department has a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, or otherwise use and authorize others to use for Federal Government purposes, software, modifications to software, and documentation that is designed, developed, installed or improved with 90 percent FFP.

(7) The costs of the system are determined in accordance with 45 CFR 74.171.

(8) The Medicaid agency agrees in writing to use the system for the period of time specified in the advance planning document approved by the Administrator or for any shorter period of time that the Administrator determines justifies the Federal funds invested.

(9) Medicaid Agency agrees in writing that the information in the system will be safeguarded in accordance with 45 CFR Part 205.50.

Section 433.113 Reduction of FFP for failure to operate a system and obtain initial approval.

(a) Except as waived under section 433.130 or 433.131, FFP will be reduced as specified in paragraph (b) of this section unless the Medicaid agency has in continuous operation a mechanized claims processing and information retrieval system that meets the following conditions:

(1) The APD for the system was approved by HCFA;

(2) The system is operational by the earlier of--

(i) September 30, 1982; or
(ii) The last day of the sixth month following the date specified for operation in the State's most recently approved APD that was submitted before October 7, 1980; and

(3) The system is initially approved by the last day of the fourth quarter that begins after the date the system became operational as determined by HCFA.

(b) HCFA will reduce FFP in expenditures for compensation and training of skilled professional medical personnel and support staff under section 1903(a)(2) of the Act, and for general administration under section 1903(a)(7) of the Act, by the following increments applied separately to those two categories of expenditures:

(1) Five percentage points for the first two quarters beginning after a deadline in paragraph (a) of this section;

(2) An additional five percentage points during each additional two-quarter period, through the quarter in which the the State achieves compliance with the conditions for initial operation or initial approval of an operating system. FFP reductions will not exceed 25 percentage points for each type of reduction.

(c) The amount of FFP (determined under section 1903(a)(3)(B)) that would be available retroactively for operating a system that later receives initial approval will be reduced by HCFA by the same percentage points for the identical periods of time described in subparagraph (b)(1) of this section, until the system is initially approved. No reduction will be made after the first quarter during which the system is initially approved.

Section 433.114 Procedures for obtaining initial approval; notice of decision.

(a) To obtain initial approval, the Medicaid agency must inform HCFA in writing that the system meets the conditions specified in § 433.116(c) through (h).

(b) If HCFA disapproves the system or determines that the system met requirements for initial approval on a date later than the date required under § 433.113(a)(3), the notice will include--

(1) The findings of fact upon which the determination was made; and

(2) The procedures for appeal of the determination in the context of a reconsideration of the resulting disallowance, to the Departmental Grant Appeals Board.

Section 433.116 FFP for operation of mechanized claims processing and information retrieval systems.

(a) Subject to § 433.113(c), FFP is available at 75 percent of expenditures for operation of a mechanized claims processing and information retrieval system approved by HCFA, from the first day of the calendar quarter after the date the system met the conditions of initial approval, as established by HCFA (including a retroactive adjustment of FFP if necessary to provide the 75 percent rate beginning on the first day of that calendar quarter).

(b) HCFA will approve the system operation if the conditions specified in paragraphs (c) through (h) of this section are met.

(c) The conditions of § 433.112(b)(1) through (4) and (7) through (9), as periodically modified under section 433.112(b)(2) must be met.

(d) The system must have been operating continuously during the period for which FFP is claimed.

(e) The system must provide individual notices, within 45 days of the payment of claims, to all or a sample group of the persons who received services under the plan.

(f) The notice required by paragraph (e) of this section --

(1) Must specify --

(i) The service furnished;
(ii) The name of the provider furnishing the service;
(iii) The date on which the service was furnished; and
(iv) The amount of the payment made under the plan for the service; and

(2) Must not specify confidential services (as defined by the State) and must not be sent if the only service furnished was confidential.

(g) The system must provide both patient and provider profiles for program management and utilization review purposes.

(h) If a State has a Medicaid fraud control unit certified under section 1903(q) of the Act and § 455.300 of this chapter, the Medicaid agency must have procedures to assure that information on probable fraud or abuse that is obtained from, or developed by, the system is made available to that unit. (See § 455.21 of this chapter for State plan requirements.)

Section 433.117 Initial approval of replacement systems.

(a) A replacement system must meet all conditions of initial approval of a mechanized claims processing and information retrieval system.

(b) The agency must submit an APD that includes--

(1) The date the replacement system will be in operation; and

(2) A plan for orderly transition from the system being replaced to the replacement system.

(c) FFP is available at--

(1) 90 percent in expenditures for design, development, and installation in accordance with the provisions of § 433.112; and

(2) 75 percent in expenditures for operation of an approved replacement system in accordance with the provisions of § 433.116(b) through (h), from the date that the system met the conditions of initial approval, as established by HCFA.

(d) FFP is available at 75 percent in expenditures for the operation of an approved system that is being replaced (or at a reduced rate determined under §433.120 of this subpart for a system that has been disapproved) until the replacement system is in operation and approved.

Section 433.119 Conditions for yearly reapproval; notice of decision.

(a) HCFA will review yearly each system operation initially approved under § 433.114 and reapprove it for FFP at 75 percent of expenditures if the following conditions are met:

(1) The system meets the conditions of § 433.112(b) (1), (3), (4), and (7) through (9).

(2) The system meets the conditions of § 433.116(d) through (h).

(3) The system meets the performance standards for reapproval and the system requirements in Part 11 of the State Medicaid Manual as periodically amended.

(b) HCFA will issue to each Medicaid agency by the end of the first quarter after the fiscal year of the review, a written notice informing the agency whether its system is reapproved or disapproved. If the system is disapproved, the notice will also include--

(1) HCFA's decision to reduce FFP for system operations, and the percentage to which it is reduced, beginning with the next calendar quarter.

(2) The findings of fact upon which the determination was made; and

(3) A statement that State claims in excess of the reduced FFP rate will be disallowed and that any such disallowance will be appealable to the Grant Appeals Board

Section 433.120 Procedures for reduction of FFP after yearly reapproval review.

(a) If HCFA determines after the yearly review that the system no longer meets the conditions of reapproval in § 433.119, HCFA will reduce FFP for systems operations for at least four quarters. However, no system will be subject to reduction of FFP for at least the first four quarters after the quarter in which the system is initially approved as eligible for 75 percent FFP.

(b) HCFA will reduce FFP in expenditures for system operation from 75 percent to no more than 70 percent and no less than 50 percent; however, HCFA will not reduce FFP by more than 10 percentage points in any four-quarter period. The percentage to which the FFP is reduced will depend primarily on the following criteria:

(1) The number of conditions judged unsatisfactory;

(2) The extent to which conditions were not met;

(3) The significance of the unsatisfactory conditions in overall mechanized claims processing and information retrieval system operations; and

(4) The actual and potential program impact attributable to the unsatisfactory conditions.

Section 433.121 Reconsideration of the decision to reduce FFP after the yearly review.

(a) The agency may appeal to the Departmental Grant Appeals Board, under 45 CFR part 16, a disallowance concerning a reduction in FFP claimed for system operation caused by a disapproval of the State's MMIS. If the Board finds such a disallowance to be appropriate, the discretionary determination to reduce FFP by a particular percentage amount (instead of by a lesser percentage) is not subject to review by the Board unless the percentage reduction exceeds the range authorized by section 1903(r)(4)(B) of the Act.

(b) The decisions concerning whether to restore any FFP retroactively and the actual number of quarters for which FFP will be restored under section 433.122 of this subpart are not subject to administrative appeal to the Grant Appeals Board under 45 CFR part 16.

(c) An agency's request for a reconsideration before the Board under paragraph (a) of this section does not delay implementation of the reduction in FFP. However, any reduction is subject to retroactive adjustment if required by the Board's determination on reconsideration.

Section 433.122 Reapproval of a disapproved system.

When FFP has been reduced under section 433.120(a), and HCFA determines upon subsequent yearly review that the system meets all current performance standards, system requirements and other conditions of reapproval, the following provisions apply:

(a) HCFA will resume FFP in expenditures for system operations at the 75 percent level beginning with the quarter following the yearly review determination that the system again meets the conditions of reapproval.

(b) HCFA may retroactively waive a reduction in FFP in expenditures for systems operations if HCFA determines that the waiver could improve the administration of the State Medicaid plan. However, HCFA cannot waive this reduction for any quarter before the fourth quarter immediately preceding the quarter in which HCFA issues the determination (as part of the yearly review process) stating that the system is reapproved.

Section 433.123 Notification of changes in system requirements, performance standards or other conditions for approval or reapproval.

(a) Whenever HCFA modifies system requirements or other conditions for approval under sections 433.112 or 433.116, or performance standards or other conditions of reapproval under section 433.119, HCFA will --

(1) Publish a notice in the Federal Register making available the proposed changes for public comment;

(2) Respond in a subsequent Federal Register notice to comments received; and

(3) Issue the new or modified standards or conditions in the State Medicaid Manual.

(b) For changes in system requirements or other conditions for approval, HCFA will allow an appropriate period for Medicaid agencies to meet the requirement determining this period on the basis of the requirement's complexity and other relevant factors.

(c) For performance standards and other conditions for reapproval, HCFA will notify Medicaid agencies at least one calendar quarter before the review period to which the new or modified standards or conditions apply.

Section 433.127 Termination of FFP for failure to provide access to claims processing and information retrieval systems.

HCFA will terminate FFP at any time if the Medicaid agency fails to provide State and Federal representatives with full access to the system, including onsite inspection. HCFA may request such access at any time to determine whether the conditions in this subpart are being met.

Section 433.130 Waiver of conditions of initial operation and approval.

(a) HCFA will waive requirements for initial operation and approval of systems under section 433.113 for a State meeting the requirements of paragraph (b) of this section and that had a 1976 population of less than one million and made total Federal and State Medicaid expenditures of less than $100 million in fiscal year 1976. Population figures are those reported by the Bureau of the Census. Expenditures for fiscal year 1976 are those reported by the State for that year.

(b) To be eligible for this waiver, the agency must submit its reasons to HCFA in writing and demonstrate to HCFA's satisfaction that an MMIS will not significantly improve the efficiency of the administration of the State plan.

(c) If HCFA denies the waiver request, the notice of denial will include--

(1) The findings of the fact upon which the denial was made; and

(2) The procedures for appeal of the denial.

(d) If HCFA determines, after granting a waiver, that an MMIS would significantly improve the administration of the State Medicaid program, HCFA may withdraw the waiver and require that a State obtain initial approval of an MMIS within two years after the date of waiver withdrawal.

Section 433.131 Waiver for noncompliance with the conditions of approval and reapproval.

If a State is unable to comply with the conditions of approval or of reapproval and the noncompliance will cause a percentum reduction in FFP, HCFA will waive the FFP reduction in the following circumstances:

(a) Good Cause. If HCFA determines that good cause existed, HCFA will waive the FFP reduction attributable to those items for which the good cause existed. A waiver of FFP consequences of the failure to meet the conditions of approval or reapproval based upon good cause will not extend beyond two consecutive quarters.

(b) Circumstances beyond the control of a State. The State must satisfactorily explain the circumstances that are beyond its control. When HCFA grants the waiver, HCFA will also defer all other MMIS deadlines for the same length of time that the waiver applies.

Related Regulations

Other regulations which authorize requirements contained in this guide for all levels of FFP are:

45 CFR Part 74 - Administration of Grants
42 CFR 431.15 - Methods of Administration
42 CFR 431, Subpart F - Safeguarding Information on Applicants and Recipients
42 CFR 431.16-17 - Reports and Maintenance of Records
42 CFR 432 - State Personnel Administration
42 CFR 433.34 - Cost Allocation
42 CFR 433, Subpart A - Federal Matching Provisions
42 CFR 433, Subpart D - Third Party Liability
42 CFR 447 - Payments for Services
42 CFR 455 - Program Integrity
42 CFR 456 - Utilization Control
45 CFR 95, Subpart F - Automatic Data Processing Equipment and Services -Conditions for Federal Financial Participation

GENERAL

CHAPTER 1

	Section	Page
Background	11100	11-1-3
Introduction	11105	11-1-3
Definitions	11110	11-1-4
Objectives	11115	11-1-7

11100 BACKGROUND

The Medicaid program, enacted in 1965 under title XIX of the Social Security Act, is a Federal-State Medical Assistance Program administered by each State according to an approved State plan. Under this plan, a State reimburses providers of medical assistance to individuals found eligible under title XIX and various other titles of the Act.

In October 1972, PL 92-603 was enacted in which §235 provided for 90-percent Federal Financial Participation (FFP) for design, development, or installation, and 75-percent FFP for operation of State mechanized claims processing and information retrieval systems approved by the Secretary. An implementing regulation, 45 CFR 250.90, was published May 20, 1974, and the supporting Part 7 of the Medical Assistance Manual, Program Regulation Guide (MSA-PRG-31) was published June 10, 1974. This regulation and guideline have provided the basis for Federal review and approval of State requests for 90-percent and 75-percent FFP under §1903(a)(3) of the Social Security Act. A requirement of §1903(a)(3) that all recipients of Medicaid services receive written notice regarding these services was amended (PL 95-142 on October 25, 1977) to allow such notices to be sent to a recipient sample rather than to all recipients. Subsequent reorganization and clarification of 45 CFR 250.90 have been made with the current regulation contained in 42 CFR 433 subpart C. The most recent addition of §1903(r) to title XIX of the Social Security Act was provided by §901 of Public Law 96-398, enacted October 7, 1980. Section 1903(r) requires that all States with Medicaid programs have approved mechanized claims processing and information retrieval systems unless waived by the Secretary. States that did not comply were subject to reductions of FFP.

11105 INTRODUCTION

A Medicaid Management Information System (MMIS), once implemented and properly utilized by a State, becomes an important and comprehensive management tool for efficient, effective, and economical administration of a title XIX program. The MMIS referred to in this part is intended to identify successful program and administrative practices which increase the quality of services and reduce the costs of the State Medicaid program.

The MMISs approved for enhanced FFP have been particularly effective tools in improving State management of Medicaid expenditures. They have enabled States to efficiently process claims and control program expenditures. These systems generate data for the States which identify instances of program abuse in the Medicaid program. They also provides data for Federal reporting needs.

Processes for approval of FFP at the 90-percent and 75-percent level have been established to encourage States to meet Federal MMIS system requirements. These processes and other applicable system requirements are described in this part.

11110 DEFINITIONS 1/

A. Administrator means the Administrator of HCFA or his authorized designee to whom he has delegated the authority and responsibility for approvals of FFP for MMIS activities.

B. Advance Planning Document (APD) means a written plan of action, conforming to the definition of APD in 45 CFR 95.605 it will inform HCFA of tne State's plan for system improvement in order to claim increased FFP for the design, development, installation, or improvement of an automated claims processing and information retrieval system. This plan normally results from an analysis of program, management, and current system needs, whether the work is to be performed by a contractor or State personnel. The APD includes the detailed implementation plan (DIP). See §11236.

C. Automatic Data Processing (ADP) means data processing performed by a system of electronic or electrical machines so interconnected and interacting as to minimize the need for human assistance or intervention.

D. Automatic Data Processing (ADP) Services means services to operate ADP equipment, either by private sources, by employees of the Medicaid agency, or by State or local organizations other than the Medicaid agency; and/or

Services provided by private sources, by employees of the Medicaid agency or by State and local organizations other than the Medicaid agency to perform such tasks as feasibility studies, system studies, system design efforts, development of system specifications, system analysis, programming, and system implementation.

E. Certification Review is the approval process by which HCFA determines if a State satisfies the approved APD, and/or if a State's title XIX mechanized claims processing and information retrieval system is operational and continuously meets requirements for FFP, as defined in §1903(a)(3) of the Act, 42 CFR 433 Subpart C and Part 11 of the SMM.

1/ See also regulatory definitions on pages iv-v.

F. Data Processing means the preparation of source data or basic elements of information and use according to precise rules or procedures to accomplish such operations as classifying, sorting, calculating, summarizing, recording, transmitting, information retrieval, and reporting.

G. Demonstrable Conceptual Equivalence describes a concept which permits States to demonstrate that a system is technically different from the MMIS-GSD but still satisfies the objectives and functions of the MMIS-GSD, and is, therefore, its conceptual equivalent.

H. Detailed Implementation Plan (DIP) is a part of the APD and details work to be performed by State personnel and/or by contract, and/or technical assistance and identifies specific schedule of milestones/deliverables and related dates. It also includes costs allocated to the design, development, installation, and improvement efforts. See § 11237.

I. Early and Periodic Screening Diagnosis and Treatment (EPSDT) is a type of medical service which provides early and periodic screening and diagnosis of eligible individuals under age 21 to ascertain their physical or mental defects. Health care, treatment and other services are provided to correct or ameliorate defects and chronic conditions discovered, as provided in regulations by the Secretary (42 CFR 441, Subpart B).

J. Feasibility Study means a preliminary study to determine whether it is sufficiently probable that effective and efficient use of automated Medicaid systems including ADP equipment and operating systems can be made to warrant the substantial investment of staff, time, and money.

K. Federal Financial Participation (FFP) means the Federal Government's share of a State's expenditures under the Medicaid program. Under §1903 of the Act, 90% and 75% FFP is provided as enhanced funding for system expenditures, and 50% FFP for all general administrative expenditures.

L. Medicaid Agency means the single (SA) administering or supervising the administration of a State Medicaid plan under §1902(a)(5).

M. Medicaid Management Information System (MMIS) is the general system design for a mechanized claims processing and information retrieval system recommended by HCFA for implementation of the requirements of 42 CFR 433 Subpart C. The most current version of the publication is "Medicaid Management Information System - General Systems Design (GSD) for title XIX," June 10, 1974, (accession #PB-236-550 - Set, National Technical Information Service (NTIS)). Copies are available for purchase from:

National Technical Information Service
U.S. Department of Commerce
5285 Port Royal Road
Springfield, VA. 22161.

(See Exhibit §11375.2) When a State has an approved APD, the MMIS for that State is the system which must meet the design standards and other requirements imposed by the Secretary.

N. Provider means any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency.

O. Request for Proposal (RFP) means the document used for public solicitations of competitive proposals from qualified sources.

P. Shared On-Line System means data processing equipment, devices, programs, and stored data, which may be accessed by two or more users utilizing either local or remote ability to interact with and under the control of a single central processing unit. Such a system can be used jointly between user States or between users within a State in the administration of such State's plan and the plan of any other State approved under title XIX.

Q. State Plan or the Plan means the comprehensive written commitment by a Medicaid agency, submitted under §1902(a) of the Act, which has been approved by HCFA, to administer or supervise the administration of a Medicaid program in accordance with Federal and State requirements.

R. Systems Analysis means the examination of existing information flow and operational procedures within an organization. This analysis essentially consists of three basic phases: data gathering, investigation of the present system and new information requirements; analysis of the data gathered in the investigation; and synthesis, or refitting of the parts and relationships uncovered through the analysis into an efficient system.

S. Systems Maintenance means those normal ongoing or cyclical automatic data processing activities which insure that data, files, and programs of the State's mechanized claims processing and information retrieval system are kept up to date and/or that errors are reduced.

T. The Act means the Social Security Act. Most of the references to the Act are to title XIX of the Social Security Act which is titled "Grants to States for Medical Assistance Programs."

11115 OBJECTIVES

The intent of §1903(a)(3) of the Social Security Act is to provide increased Federal financial support to State Medicaid agencies for mechanization of Medicaid claims processing and information retrieval systems or for approved changes to such mechanized systems. In so doing, it is expected that the States will realize more efficient and effective administration of the Medicaid program. The objectives of system mechanization and improvements are:

A. Program

- o Reduction in program and administrative costs through more effective claims processing and utilization control; and
- o Improved management of program and administrative costs.

B. Service

- o Improved service and information to recipients,
- o Reduced time to pay providers; and
- o Improved response time to inquiries.

C. Operations

- o Reduction in claims personnel requirements;
- o Increased utilization of computer capability;
- o Greater utilization of data base;
- o Improved operational control and audit trails;
- o Capability to handle increases in claims volume;
- o Reduction of systems audit exceptions; and
- o Compatibility with Medicare claim processing and information retrieval systems for the processing of Medicare claims.

D. Management

- o Timely and effective reports for management planning and control;
- o Improved analyses for decision making;
- o Improved ability to respond to request for special analyses; and
- o Improved capability to support Federal reporting requirements.

CHAPTER 2

	Section	Page
Applicable Federal Approval Requirements	11200	11-2-3
90-Percent FFP -General Regulatory Requirements	11205	11-2-3
Requirement for Initial Approval	11207	11-2-4
75-Percent FFP - General Regulatory Requirements	11210	11-2-4
Initial Approval of Integrated Eligibility Systems	11210.1	11-2-5
Access for State and Federal Inspection	11215	11-2-5.2
Considerations and Options	11225	11-2-5.2
Purchase of ADP Equipment and Services	11227	11-2-7
Approval Process and Documentation Submissions	11230	11-2-7
90-Percent FFP	11235	11-2-8
First Stage of the Advance Planning Document (APD)	11236	11-2-8
Detailed Implementation Plan (DIP)-- the Second Stage of the APD	11237	11-2-8
75-Percent FFP - Federal Certification Review Process	11240	11-2-10
Preliminary Evaluation	11241	11-2-10
On-Site Observation	11242	11-2-11
Post-Site Evaluation	11243	11-2-12
Reimbursable Costs for State MMIS	11250	11-2-12
Transition Funding 90 and 75-percent FFP	11255	11-2-12
Retroactive 75-percent FFP	11260	11-2-13
Contractual Services	11265	11-2-14
Request for Proposal (RFP)	11266	11-2-14
Required Assurances	11267	11-2-16
Cost Allocation Plan	11268	11-2-16
Replacement Systems	11269	11-2-16
75-Percent FFP --Reviews for the Reapproval Process--the System Performance Review	11270	11-2-17
75-Percent FFP--Procedures for Reduction of FFP After Reapproval Review	11270.1	11-2-18

75-Percent FFP --Reconsideration of the Decision to Reduce FFP After Review..... 11270.2 11-2-18
75-Percent FFP --Reapproval of a Disapproved System..... 11270.3 11-2-19
Limited Waiver of the Requirement for Initial Approval of a System, or a Replacement System, and the Requirement for Reapproval..... 11271 11-2-19

Exhibits..... 11275 11-2-20

11200 APPLICABLE FEDERAL APPROVAL REQUIREMENTS

The most current Public Laws and Federal regulatory requirements, guides, and system requirements identified in Chapter 3 of this part form the basis upon which State design, development, installation, operations, and MMIS system improvements will be evaluated for approval of increased FFP. States must receive approval of HCFA prior to the expenditure of any funds for MMIS in order to qualify for enhanced matching. HCFA will not give retroactive approval. Moreover, if the ADP procurement meets the threshold requirements of 45 CFR 95.601 et seq., no FFP (even at the 50 percent rate) would be available unless the appropriate prior approval is obtained. Whenever HCFA modifies requirements for approval of systems under 42 CFR 433.112 and 433.116, provisions of 42 CFR 433.123 will be followed.

11205 90-PERCENT FFP - GENERAL REGULATORY REQUIREMENTS

FFP is available at 90 percent for expenditures for design, development, installation, or improvement of a mechanized claims processing and information retrieval system. In order to receive 90-percent FFP, a system proposal described in the APD must be approved by HCFA prior to the State's expenditure of funds. HCFA will approve the system proposal if the following conditions are met (42 CFR 433.112):

o HCFA determines the system is likely to provide more efficient, economical, and effective administration of the State plan.

o The system meets the system requirements and performance standards in Part 11 of the SMM, as periodically revised.

o The system is compatible with the claims processing and information retrieval systems used in the administration of Medicare for prompt eligibility verification and for processing claims for persons eligible for both programs.

o The system supports the data requirements of Peer Review Organizations (PRO) established under Part B of title XI of the Act.

o The State owns any software designed, developed, installed or improved with 90-percent FFP.

o The Department has a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, or otherwise use and authorize others to use, for Federal Government purposes, software, modifications to software, and documentation that is designed, developed, installed or improved with 90-percent FFP.

o The costs of the system are determined in accordance with 45 CFR 74.171

o The Medicaid agency agrees in writing to use the system for the period of time specified in the APD approved by HCFA or for any shorter period of time that HCFA determines justifies Federal funds invested.

o The Medicaid Agency agrees in writing that the information in the system will be safeguarded in accordance with 42 CFR Part 431.

11207 REQUIREMENT FOR INITIAL APPROVAL

Since September 30, 1982, States with Medicaid programs were required by §1903(r) to have an approved and operating MMIS unless this requirement was waived by HCFA. After approval, the State must continuously operate an approved system or face reduction in FFP in expenditures for operation of a disapproved system. If a State abandons an approved system and does not replace it with another, the penalties for failure to meet the deadline for receiving initial approval would apply.

Commonwealths, territories and possessions of the United States received waivers from the requirements of §1903(r)(7). Under §1903(r)(7) (42 CFR 433.130), States that had fewer than one million residents in 1976 and total Federal and State expenditures of less than $100 million dollars in fiscal 1976 were entitled to receive a waiver of the initial operation and approval requirements upon showing that the application of those requirements would not significantly improve the efficiency and administration of their Medicaid programs. To obtain this waiver, a State had to submit the applicable information to HCFA. If after granting this waiver, HCFA determines that an MMIS would significantly improve administration of the State Medicaid program, HCFA may withdraw the waiver and prepare a timetable for compliance. This timetable will be comparable to the time period allowed under §1903(r) for an initial approval of the other States' operating systems, which is 2 years.

If a State does not have an approved operating system by the deadline, it will be subject to percentum reductions of FFP (§1903(r)(2)(C) and 42 CFR 433.113). HCFA will reduce FFP in expenditures for compensation and training of skilled professional medical personnel and support staff provided by §1903(a)(2) and for general administration of the Medicaid program provided by §1903(a)(7). Reductions to both expenditures will be in increments of five percentage points. There will be a five percentage point reduction for the first two quarters beginning after the deadline for initial approval. There will be an additional five percentage point reductions for every two-quarter period beyond the deadline for initial approval. These FFP reductions will not exceed a total of 25 percentage points for each type of expenditure. The reduction of the funds for skilled medical professional personnel and general administrative funds shall apply through the quarter in which the State achieves compliance with the conditions for initial approval of an operating system.

11210 75-PERCENT FFP - GENERAL REGULATORY REQUIREMENTS

FFP is available at 75 percent of expenditures for operation of a mechanized claims processing and information retrieval system approved by HCFA. HCFA will approve the system's operation if the following conditions are met (42 CFR 433.116):

o The applicable requirements of §11205, must be met.

o The complete system with all its component subsystems is and has been operating continuously, processing all claims types, during all periods for which FFP is claimed.

o The system provides individual notices, within 45 days of the payment of claims, to all or a sample group of the persons who received services under the plan. The notice "Explanation of Benefits (EOB)":

Must specify:

- o The service(s) furnished;
- o The names of the provider(s) furnishing the service(s);
- o The date(s) on which the service(s) were furnished; and
- o The amount of the payment(s) made under the plan for the service(s).

It must not specify confidential services (as defined by the State) and must not be sent if the only service furnished was confidential. The Department, while giving the State flexibility in defining "confidential services," expects that States will exclude from EOBs only those particularly sensitive services for which disclosure will violate a beneficiary's right to privacy, e.g., family planning services, venereal disease treatment.

o The system must provide both patient and provider profiles for program management and utilization review purposes.

o If the State has a Medicaid fraud control unit certified under §1903(q) of the Act and 42 CFR 455.300, the Medicaid agency must have procedures to assure that information on probable fraud and abuse that is obtained from, or developed by, the system is made available to that unit.

o HCFA will review the system periodically against requirements in §11210 to determine whether the system continues to meet provisions of this part, including the systems requirements, performance standards and other conditions of approval.

11210.1 Initial Approval of Integrated Eligibility Systems.--FFP at the 75-percent rate of reimbursement for the title XIX share of the operational costs of integrated eligibility systems is available provided the following requirements for such systems are met.

A. Developmental Funding.--For the title XIX share of the operational costs of an integrated eligibility system to be matched at the 75-percent FFP rate, HCFA must have provided funding at the 90-percent rate of reimbursement for some portion of the overall system development costs.

B. Request for HCFA Approval.--Within 30 days of the system becoming fully operational, provide the Director, Bureau of Quality Control (BQC), HCFA, with:

- o The date the system became fully operational statewide.

o Certification that all Medicaid specific functions and objectives identified in the federally approved advance planning document for the system and modification thereto are being performed and have been met.

o A list of all Medicaid specific functions performed by the system.

o The relevant system documentation for each of these functions. A description of what this system documentation should encompass is found in subsection D.

o An estimate of the share of the operational costs allocated to HCFA and the methodology used to arrive at this allocation.

C. HCFA Determination Process.--After acknowledging receipt of this material, HCFA determines which review process it will employ in formally approving the title XIX portion of the integrated eligibility system. The two review methodologies are:

o A review in HCFA central office (CO) of the system's documentation in conjunction with an analysis of the outcome of the Family Support Administration (FSA) certification review; or

o A review in HCFA CO of the system's documentation followed by a HCFA postinstallation, onsite review of the system.

Which of these methodologies HCFA employs depends on an analysis of these factors as they relate to the integrated eligibility system:

o The magnitude of the title XIX financial investment in the development and operation of the system.

o Whether the State has a medically needy program and/or is a 209(b) State.

o The judgment of the HCFA regional office (RO) as to the operational effectiveness of the system.

o The judgment of the other operating divisions (FSA and the Food and Nutrition Service of the Department of Agriculture) as to the capabilties of the system.

o The findings of the FSA certification review.

D. Required System Documentation

o A narrative description of the system architecture.

o An overall system flow chart identifying the computer programs, files, process flow, and external interfaces which highlights the Medicaid specific aspects of the system.

o A narrative description of each Medicaid specific computer program, module, routine, and file within the system.

o A data element dictionary with each Medicaid data element identified as such, as well as a description of all edits pertaining to these data elements.

o A list of all Medicaid specific reports and outputs produced by the system accompanied by a sample copy of the appropriate report or record layout.

o Record layouts of all files with the Medicaid specific fields so annotated.

o User manual(s) including a list of system error codes with explanations and procedures for corrective actions.

o Training manual(s).

o The results of the acceptance testing of the Medicaid portions of the system.

This list is not an all-inclusive list of system documentation. You may submit other types of system documentation to demonstrate how your integrated eligibility supports the Medicaid program.

E. Outcome.--Within 6 months of the operational date of the system (assuming you have submitted the required documentation within the timeframe specified in subsection B), HCFA will officially inform you whether the integrated eligibility system is approved, i.e., whether you may claim enhanced FFP for the title XIX share of the operational costs of the system.

11215 ACCESS FOR STATE AND FEDERAL INSPECTION

HCFA will terminate enhanced FFP if you fail to provide State and Federal representatives with full access to the system, including onsite inspection. HCFA may request such access at any time to determine whether conditions in subpart 42 CFR 433.127 are met.

11225 CONSIDERATIONS AND OPTIONS

When the State has determined the desirability of designing an MMIS or effecting system improvements which may lead to increased FFP under the requirements of this part, consideration may be given to "demonstrable conceptual equivalence" and to other options. The following options are among those that may be considered:

o A State does not need to have a single comprehensive claims payment and information retrieval system through which all claims for types of service are processed to claim the higher FFP under § 1903(a)(3). A State may have multiple claims payment systems provided:

- They do not appreciably increase cost or detract from the primary benefits expressed in this part;

- Each system meets the established criteria in this part; and

- All systems feed into a single comprehensive utilization and management reporting system that meets the criteria established in this part. Under this approach, all of these components (subsystems) comprise the MMIS.

o Other mechanized information retrieval systems under title XIX, such as EPSDT, TPL, and LTC, are eligible for the higher FFP allowed by §1903(a)(3) provided:

- A State has an approved APD for the design, development, and installation of a claims payment and information retrieval system.

- The systems are used to store, retrieve, and produce utilization and management information about such medical care and services which are required by the Medicaid Agency and Federal Government for program administration and audit purposes;

- None of the design and operational aspects of such information retrieval system cause other statutory criteria, such as compatibility with information retrieval systems used by Medicare, to be violated;

- HCFA determines that such systems are likely to provide more efficient, economical, and effective administration of the plan, and

- All procedures that are established in 42 CFR 433, Subpart C are followed (i.e., the submission of an APD, prior HCFA approval is obtained before the expenditure of any funds for MMIS to qualify for enhanced matching in these expenditures, etc.)

These additional systems are not part of the core (i.e., required) MMIS, but qualify for enhanced FFP as optional components (subsystems).

o Options in regard to installation and operation of a proposed or existing MMIS, depending on facilities, personnel, management capability, and funding may be:

1. State Installs and Operates: You may install an MMIS or improvements on your own computer using State personnel for systems and programming.

2. State Contracts for Installation-State Operates: You may contract under a competitive procurement process with a third party to design and install an MMIS or improvements on the State's computer system for an agreed upon price. State personnel would then assume operating responsibility.

3. State Contracts for Installation on a Turnkey Basis the Medicaid Agency may contract under a competitive procurement process with a third party to design and install an MMIS or improvements on the Medicaid Agency's computer system. The contract may also provide for the training of machine operators, systems programmers, and clerical support personnel to assume operation of the system at an agreed time after installation.

4. State Contracts for Installation and Operation the Medicaid Agency may contract under a competitive procurement process with a third party to design and install an MMIS or improvements on that third party's computer system. The contract to operate the system need not be with the same contractor that designed the system.

11227 PURCHASE OF ADP EQUIPMENT AND SERVICES

For 90-percent FFP, prior approval of the APD is required for all purchases regardless of the dollar amount (42 CFR 433.112(b)). No FFP is available at 90-percent without an approved APD. The enhanced FFP is not available in excess of the amount approved in the APD without additional prior approval.

For 75-percent FFP, a State must obtain written approval of the RFP from HCFA, prior to the expenditure of funds, when it plans to acquire ADP equipment or services that it anticipates will have total acquisition costs of $100,000 or more in Federal and State funds over a 12-month period; or of $200,000 or more in Federal or State funds for the total acquisition. A State must also obtain prior written approval when it plans to acquire noncompetitively, from a commercial source, ADP equipment or services that cost more than $25,000 in Federal and State funds. This requirement applies regardless of which option in §11225 is used by the State. These requirements are specified in 45 CFR Part 95 Subpart F.

For contractual services, including fiscal agent contracts, as described in §11265, the prior approval requirements are also applicable, including the situation in which a State has a system owned and operated by the contractor. These requirements (including the $100,000 threshold for a 12-month period, the $200,000 or more for total acquisition, etc.) for purchase of ADP equipment and services are required for 50-percent FFP, under §1903(a)(7). No FFP (even at the 50% rate) would be available unless the appropriate prior approval is obtained. These requirements are specified in 45 CFR Part 95 Subpart F and the Part 2 §§2080ff.

11230 APPROVAL PROCESS AND DOCUMENTATION SUBMISSIONS

Sections 11235 through 11243 present the approval process to follow by the Medicaid Agency in obtaining increased FFP under 42 CFR 433 Subpart C. Exhibit §11275.1, is a graphic display of the procedural steps. Forward the required submittals to the appropriate HCFA Regional Administrator.

11235 90-PERCENT FFP

The approval process for 90-percent FFP requires submission of the following documents, as appropriate:

- Advance Planning Document (§11236);
- Detailed Implementation Plan (§11237); and
- Contracted Services Documents (§§11265 thru 11267).

11236 FIRST STAGE OF THE ADVANCE PLANNING DOCUMENT (APD)

The approval process for 90-percent FFP begins with the submission first stage of the State's APD. This informs HCFA of the State's plan for system improvement in order to claim increased FFP for design, development, installation, or improvement of an automated claims processing and information retrieval system. It also used to indicate whether work is to be performed by a contractor or by State personnel. It must provide:

- A statement of system objectives;
- The scope and nature of activities to be undertaken including the methods to be used;
- A proposed activity schedule for accomplishing the objectives;
- The estimated cost including a cost/benefit justification appropriate to the scope and cost;
- A personnel resource statement indicating availability of qualified and adequate staff, including the identification of a project director, to accomplish the project objectives; and
- Agreements in accordance with 42 CFR 433.112(b)(5)-(9).

Approvals, disapprovals, comments, and/or suggestions will be sent to the Medicaid Agency, in writing, through the Regional Administrator, HCFA.

Reimbursable costs for 90-percent are categorized by Exhibits 11275.2 and 11275.26.

If work is to be performed under contract, see §§11265 through 11267.

11237 DETAILED IMPLEMENTATION PLAN (DIP)--THE SECOND STAGE OF THE APD

A State Detailed Implementation Plan (DIP) is required as part of the APD as defined in 42 CFR § 433.111 for HCFA approval prior to the design of the system and may

be developed by State personnel or by contract. It must include a provision for identifying costs allocated to the design, development, and installation, or improvement effort. In general, the DIP includes:

- o System Definition.
- o Approach to Completing the Project.
- o Nature and Scope of the Work.
- o Project Schedule and Deliverables.
- o Project Resource Requirements.
- o Project Organization and Staffing.
- o Project Interface with the Affiliated Organizations and Systems.
- o Project Reporting Requirements.
- o Estimated Costs.
- o System Acceptance and Approvals.
- o Conversion Plans, as required.

Periodic status reports are required, as requested, for system phases reimbursable at 90-percent FFP. They may be augmented by onsite reviews by authorized Federal or State program or audit personnel. The purposes of these onsite reviews are to assess:

- o The current validity of the original plan developed in §11236 A;
- o Progress against the detailed implementation plan; and
- o The validity of accounting and cost allocation records maintained.

Changes to the State's implementation plan are subject to prior approval.

The State will send a letter of notification to HCFA that the system has been tested and accepted and is ready for review for operational FFP.

11240 75-PERCENT FFP - FEDERAL CERTIFICATION REVIEW PROCESS

The Federal review process, for FFP at 75 percent, occurs in three phases: Preliminary evaluation of State furnished information and system documentation; State visit On-site observation of ongoing system operations; and Post-site evaluation report of findings and recommendation to the Regional Administrator, HCFA. The phases are explained in following sections.

11241 PRELIMINARY EVALUATION

The Federal review process is initiated when a State submits a written statement of intent to claim enhanced FFP for operations and supporting systems documentation. The statement of intent must assure HCFA that system operations meet requirements of §§11210 and 11215 including systems requirements and performance standards of chapter 3 of this Part. Include:

- The date the complete system was officially accepted by the State as operational;
- The dates of operations covered by any claim;
- Certification that requirements have been met for any and all periods of the claim; and
- Certification that EOBs have been issued within 45 days of the payment of a claim to each individual who is furnished services covered by the State plan or to each individual in a sample group of individuals who furnished such services on a regular basis for the entire period claimed. Additionally, to expedite the review, submit in advance of the certification review the following systems documentation which should closely adhere to the format as defined in the MMIS-GSD:
- A system diagram identifying overall logic flow, systems functions, applicable computer programs, and their associated files;
- A narrative of each program including basic functions;
- A sample of each form (claim, EOB, and related documents);
- List of all error codes with explanations and procedures for corrective action;
- Record layout with field identification of all major files. (Include list of data elements);
- List of reports by each subsystem. (Include a list that identifies the distribution of all systems generated reports);
- A substantive and representative sample of all reports;
- User manuals for each subsystem; and

- Provider manuals for each provider type.

The HCFA review team will initially evaluate State system documentation and information in terms of completeness and equivalency to the system requirements contained in chapter 3 and in meeting the objectives and functions of the Federal model system. If obvious deficiencies are noted, a State may be requested to supply additional clarifying information. A minimum of 6 months of claims processing activity is required in order to adequately review the SUR reports.

If, after preliminary review, the State's submittal is satisfactory, the HCFA review team will develop a response with input from the HCFA RO that specifies the date on which the on-site review of operation will be accomplished, and the designation of the Federal team leader and members who will be the focal point for interface with the Medicaid Agency.

A time schedule agenda will be identified which will enable the State to make available those individuals involved with the subsystems of the State MMIS. The agenda will normally consist of an introductory meeting, a system overview presentation by the State, a walk-thru of the system operation, individual interviews of key Medicaid program staff, and selective validation of documents and controls associated with various functional areas of the MMIS operation. State acceptance of the agenda will be obtained prior to on-site observation to insure availablility of appropriate personnel and material.

Prior to the on-site certification review of the State's MMIS, the State will be offered the opportunity to meet with the HCFA certification review team to discuss the certification review process and any areas of concern the State may have.

11242 ON-SITE OBSERVATION

The designated Federal team leader will conduct an entrance and exit conference with the designated State officials. In the entrance conference, the agenda and planned on-site activities will be reviewed to ensure that the planned schedule will be productive. Since the time of both Federal and State personnel is limited, the schedule may have to be revised before the review can begin.

The team leader will designate areas of responsibility to team members. Normally, assignments will be made with respect to the conventional subsystem of the Federal model systems (namely: Recipient, Provider, Claims Processing, Reference File, Surveillance and Utilization Review, Management and Administrative Reporting).

The State is expected to provide space for interviews and to designate key staff and/or contractor counterparts having particular expertise concerning specific system functions. Fiscal agents or contractors of the Medicaid Agency are approached only through the State Medicaid Program Staff.

At the conclusion of the onsite review, the team leader will hold an exit conference with appropriate State officials. The team leader will discuss the activities that the HCFA review team has conducted and inform them of any additional information and/or documentation required.

The team leader will inform the State that the team will develop a report of findings together with the recommended action for approval or disapproval of the State MMIS for the Administrator who will render a decision. No judgement as to approval or disapproval will be rendered at this time.

11243 POST-SITE EVALUATION

In the post-site evaluation, individual team members will independently perform an analysis of findings and, if necessary, detailed studies prior to drafting an evaluation report covering their area of responsibility. These reports will be reviewed in conference, and the team leader will prepare a final report for signature by the Administrator with a recommendation for approval or disapproval. The decision is forwarded to the appropriate HCFA Regional Administrator who communicates the decision to the State Medicaid Agency.

If HCFA disapproves the system or determines that the system met the requirements for initial approval on a date later than the date required under 42 CFR 433.113(a)(3) (§11207), the notice will include:

- The finding of fact upon which the determination was made; and
- The procedures for appeal of the determination in the context of a reconsideration of the resulting disallowance, in the event the full FFP rate is claimed, to the Departmental Grant Appeals Board.

11250 REIMBURSABLE COSTS FOR STATE MMIS

Attributable costs reimbursable at the 90-percent and 75-percent FFP for State MMIS activities involving the design, development, installation, operation, and improvement of mechanized claims processing and information retrieval systems are in Exhibit 11275.2.

11255 TRANSITION FUNDING - 90-AND 75-PERCENT FFP

Projects for designing, developing, installing, or improving an automated claims processing and information retrieval system will be funded during the transition between 90-percent FFP and 75-percent FFP as follows:

o FFP at the 90-percent level is available for design, development, installation, or improvement of each subsystem in an approved complete system meeting the requirements of §11205.

o FFP at the 90-percent level for any subsystem terminates on the date the subsystem or improvement to a subsystem is fully tested and subsequently accepted by the State.

o FFP at the 50-percent level is available for operation of any subsystem from that point that 90-percent FFP ceases until the complete system is fully operational and meets the requirements of §11210.

o FFP at the 75-percent level is available prospectively from the date the system is approved and retroactively to the date that the complete approved system is determined to be fully operational and meets all requirements as defined in §11210. (See §11260 for the retroactive approval process).

11260 RETROACTIVE 75-PERCENT FFP

Section 1903(a)(3) provides for an effective date of July 1, 1971 and §1903(r)(3) further defines retroactive payments. A claim for retroactive enhanced FFP may be made for systems operations begun during any period on or after July 1, 1971. The State can obtain increased operational FFP retroactive to the first quarter beginning after the date established by the Secretary that the system became operational. HCFA will conduct a certification review prior to authorization of retroactive FFP. The State in making a claim for retroactive 75-percent FFP must submit a written statement to the effect that its system operations have been reviewed by HCFA and met all requirements in §§11210 and 11215 including the system requirements and performance standards of chapter 3. Identity the reviewer and include the date of the review. Also include the following:

o The date the complete system was officially accepted as operational;

o The dates of the period of operations claimed;

o Certification that the requirements have been met for the entire period for which 75-percent is being claimed; and

o Certification that EOBs have been issued within 45 days of the payment of a claim to each individual who was furnished services covered by the State plan or to each individual in a sample group of individuals who furnished such services on a regular basis for the entire period claimed.

In all cases of retroactive FFP, the State must agree in writing that the Federal Government will have access to the system and associated documentation in all of its aspects including design, development, and operations, regardless of source, including cost records of contractors and subcontractors as HCFA deems necessary.

11265 CONTRACTUAL SERVICES

Contractual services may be utilized to perform work for the design, development, installation, or improvement of a mechanized claims processing and information retrieval system. An unsolicited proposal submitted by a reputable third party firm is not sufficient for obtaining FFP under §1903(a)(3). Procurement of services must be open and competitive. Prepare a Request for Proposal (RFP) containing specific scope of work and related requirements for solicitation of bids from responsible competing systems firms. (See §11266.)

Work performed under contract to design, develop, install, or improve a mechanized claims processing and information retrieval system and meeting all the provisions of § 11205 will be funded at the 90-percent FFP level; if not, the work would then be funded at the 50-percent level. Subsequent operational costs of a certified approved MMIS would be funded at the 75-percent FFP level.

Work performed under contract for operation of an MMIS mechanized claims processing and information retrieval system and meeting the provisions of § 11210 will be funded at the 75-percent FFP level.

11266 REQUEST FOR PROPOSAL (RFP)

The State's Request for Proposal (RFP) for expenditures of State and Federal funds anticipated to be $100,000 or more in a 12 month period or $200,000 or more for total acquisition (§11227) must be approved by HCFA prior to its release to potential bidders. The RFP has a twofold purpose. The first is to convey to prospective contractors the information needed to prepare a proposal. The second is to solicit information that procurement and technical personnel need to evaluate the proposals received. The RFP must include:

o Statement of the purpose and scope of the specific work and/or services to be performed including a period of performance within which the State expects to have the work performed;

o Listing and description of the reference material available to the contractor for use in preparation of proposals and/or in performance of the contract such as: the MMIS-GSD; the available developmental documentation related to the pilot MMIS (Ohio); and other documentation prepared by HCFA;

o Requirement for a statement of the total cost to perform the contract including an estimate for individual phases or areas or the work statement;

o Standards format and organization for the proposals including both work to be performed and cost statements;

o Explanation of the proposal evaluation criteria and the relative importance of cost or price, technical, and other factors for purposes of proposal evaluation and contract award;

o Description of the nature and extent of involvement of Medicaid Agency personnel during the contract including the name and title of the project officer;

o Description of the supplies, clerical support, computer time, work space, etc., that will be made available by the State, if applicable;

o Requirement that the prime contractor is responsible for contract performance, whether or not subcontractors are used;

o Requirement for a statement of the contractor's personnel resources planned to be assigned to the contract;

o Requirement for a schedule of proposed work, defining milestones;

o Statement of contract termination procedures;

o Requirement for a statement of corporate financial stability and/or requirement for performance bond; and

o Requirement that the proposed contract include provision for retention of all ownership rights to the software by the State, if designed, developed, installed or improved at 90 percent FFP.

11267 REQUIRED ASSURANCES

For enhanced funding and for 50-percent FFP, the Medicaid Agency must give HCFA the following with respect to each RFP and/or contract entered into for MMIS.

- o Assurance of fair competition and public advertising within Federal and State procurement standards. The Federal procurement standards are in 45 CFR Part 74;

- o Assurance that copies of progress reports, as requested, will be delivered to HCFA;

- o Assurance that all deliverables, interim reports, data collection forms, questionnaires, and other working papers which support the final system acceptance will be made available on request to HCFA. This applies to the prime contractor, any subcontractors, and other State or local agencies supplying services; and

- o Assurance that procurements of ADP services and/or equipment, for mechanized medical claims processing and information retrieval systems, meet the provisions of 45 CFR Part 74, Administration of Grants.

11268 COST ALLOCATION PLAN

Document costs in a cost allocation plan approved by HCFA to support its claim for FFP. State agencies must be able to provide documentation to support wages, benefits, and other expenditure items in accordance with Federal regulations in 42 CFR 433.34, cost allocation and 45 CFR Part 95 Subpart E.

11269 REPLACEMENT SYSTEMS

The State may replace the operator of its system at any time. Enhanced FFP will continue for an approved system regardless of who operates it. A State must comply with the requirements of 45 CFR Part 74 and 45 CFR Part 95.

A State may also discontinue the operation of an approved system and replace it with a new system that is likely to be more efficient, economical and effective in administering the State Plan. The State agency must describe in its APD a plan for continuous systems operation so that there is no interruption between the end of one system and the beginning of another.

Parallel operation is possible, but only one system will be funded at the enhanced rate for operations. (This rate may be 75-percent or less, depending upon whether the current system has been disapproved.)

In order to receive enhanced FFP, a replacement system must meet all conditions of initial approval. A State must submit an APD that includes (42 CFR 433.117):

- o The date the repacement will be in operation; and
- o A plan for orderly transition from the system being replaced to the replacement system.

FFP at 90 percent is available for design, development and installation if the State meets the provisions of 42 CFR 433.112 and follows the procedures of §§11215 through 11268. When a replacement system becomes operational, FFP would be available at 50 percent for operation of the replacement system until HCFA approves it. At that time, increased FFP would be available at 75 percent retroactively to the date HCFA determined the replacement system met all conditions of approval. However, although a State may be operating both systems for a limited period of time, FFP is available at 75 percent for only one system at any time. (FFP is available at 50 percent for the other.)

11270 75-PERCENT FFP--REVIEWS FOR THE REAPPROVAL PROCESS--SYSTEM PERFORMANCE REVIEW

Approved State MMIS systems will be reviewed at least once every three years to determine whether they meet reapproval requirements, performance standards contained in Chapter 4, HCFA-mandated systems requirements contained in Chapter 3, and other conditions of reapproval. Reviews for reapproval may, at the Secretary's discretion, constitute reviews of the entire system or of only those standards, system requirements, and other conditions which have demonstrated weakness in previous reviews.

HCFA will reapprove the State's system operation for FFP at 75 percent of expenditures if the following are met:

- o The system meets the conditions of 42 CFR 433.112(b)(1),(3),(4) and (7) through (9) (§11205 as appropriate).
- o The system meets the conditions of 42 CFR 433.116 (d) and (h) (§11210 as appropriate).
- o The system meets the system requirements in this Part and the performance standards for reapproval in Chapter 4 as periodically amended.

The time period for implementing new conditions of reapproval is proposed in a Federal Register notice proposing each new reapproval requirement. After a comment period, any changes in the proposed time period will also be published in the Federal Register. States are encouraged to comment on the additional time they believe is required to implement the new requirements (should they be adopted) and explain the basis for estimates of time needed for implementation. HCFA will take into account these comments when issuing the effective date as part of the final notice.

11270.1 75-Percent FFP--Procedures for Reduction of FFP After Reapproval Review.--If HCFA determines after the reapproval review that the system no longer meets the conditions of reapproval in 42 CFR 433.119 ($11272), HCFA will reduce FFP for systems operations for at least four quarters. However, no system will be subject to reduction of FFP for at least the first four quarters after the quarter in which the system is initially approved as eligible for 75-percent FFP.

HCFA will reduce FFP in expenditures for systems operation from 75 percent to no more than 70 percent and no less than 50 percent; however, HCFA will not reduce FFP by more than 10 percent in any four-quarter period. The percentage to which the FFP is reduced depends primarily on the following criteria:

- The number of conditions judged unsatisfactory;
- The extent to which conditions were not met;
- The significance of the conditions in overall mechanized claims processing and information retrieval systems operations; and
- The actual and potential program impact attributable to the unsatisfactory conditions.

The withheld FFP will be lost permanently for the first three quarters of the calendar year in question if subsequent reapproval review shows the system still failing to meet any conditions of reapproval. During the period in which a State receives FFP for MMIS operation at a reduced rate, claims by the State for FFP at any higher level for MMIS will be disallowed; i. e. the State will not be eligible to receive 75-percent FFP for MMIS funding.

11270.2 75-Percent FFP--Reconsideration of the Decision to Reduce FFP After Review.--The agency may appeal to the Departmental Grant Appeals Board, under 45 CFR Part 16, a disallowance resulting from a reduction in FFP claimed for system operation caused by a disapproval of the State's MMIS. If the Board finds such a disallowance to be appropriate, the discretionary determination to reduce FFP by a particular percentage amount (instead of by a lesser percentage) is not subject to review by the Board unless the percentage reduction exceeds the range authorized by section 1903(r)(4)(B) of the Act.

The decisions concerning whether to restore any FFP retroactively and the actual number of quarters for which FFP will be restored under 42 CFR 433.122 ($11275) are not subject to administrative appeal to the Grant Appeals Board under 45 CFR part 16.

A request for a reconsideration before the Board of a disallowance resulting from a reduction in FFP claimed for systems operation does not delay implementation of the reduction in FFP. Reductions will be restored retroactively if the Board determines that they were not proper.

11270.3 75-Percent FFP--Reapproval of a Disapproved System.--When FFP has been reduced under 42 CFR 433.120(a) (§11273) and HCFA determines that the system meets all current performance standards, system requirements and other conditions of reapproval, the following apply:

o HCFA will resume FFP in expenditures for systems operations at the 75-percent level beginning with the quarter following the next reapproval review determination that the system again meets the conditions of reapproval.

o HCFA may retroactively waive a reduction of FFP in expenditures for system operations if it determines that the waiver could improve the administration of the State Medicaid plan. However, HCFA cannot waive this reduction for any quarters before the four quarters immediately preceding the quarter in which HCFA issues the determination (as part of the next reapproval review) stating that the system is approved. Thus, a total of five quarters of FFP reductions may be retroactively restored--the quarter in which the system is reapproved plus the immediately preceding four quarters.

11271 LIMITED WAIVER OF THE REQUIREMENT FOR INITIAL APPROVAL OF A SYSTEM OR REPLACEMENT SYSTEM AND THE REQUIREMENT FOR REAPPROVAL

HCFA will waive the FFP reductions if a State is unable to comply with a requirement of §1903(r) of the Social Security Act and of 42 CFR 433.116, 433.117 and 433.119 for good cause, e. g., the State may have had to spend more time and effort on development due to some unforeseen technical or legal difficulty. The State must explain the reason(s) for good cause. Failure of a contractor of the State to perform is not grounds for waiver. The waiver of FFP reductions will only be applied to the reductions that would have been caused by the item for which the State has good cause. If the State does not have good cause for other deficient areas, it may be possible that some reductions might still be applied. No waiver for good cause can exceeed two quarters.

The good cause waiver mitigates the FFP consequences attributable to the two quarters of poor performance which has been excused for good cause. For example, during reapproval, if a State failed to meet the MARS reporting standard because of untimely reporting during a two quarter period in which there was good cause for failure and this was the only reason that the State's system was not reapproved, it would have no FFP reduction for the year during which the system was not reapproved. However, if there were deficiencies in the other quarters which caused the State's system to fail performance review, it would be subject to reduced FFP in the year that the system was not reapproved. This is because the waiver for good cause of the FFP consequences of two quarters of inadequate performance was not sufficient to mitigate the other failures of the system to meet the standards which were not subject to a waiver.

HCFA will also waive the FFP reductions for a period during which a State is unable to comply due to circumstances beyond its control. The State must satisfactorily explain these circumstances to HCFA. This situation would exist when a State or a contractor responsible for the MMIS is without fault in being unable to comply e.g., a natural disaster or a delay caused by HCFA. HCFA will also defer all remaining deadlines for the initial approval process for the same length of time.

11275 EXHIBITS

EXHIBIT 11275.1 Approval Process and Documentation Submissions 11-2-21

Exhibit 11275.2 Costs Related to State MMIS Design, Development, Installation, Operation, and MMIS Improvement 11-2-24

Exhibit 11275.5 Effective Date of Part 11 11-2-43

Exhibit 11275.1 Approval Process and Documentation Submissions

Task Phase/Events	FFP Matching Rate	HCFA Prior Approval**	Required Submittals
TO OBTAIN 90-PERCENT FFP			
1. Feasibility Study*	50%	N/A	N/A
2. First Stage of Advanced Planning Document(APD) for increased FFP for systems	50%	N/A	N/A
3. Detailed State implementation plan, (as part of the APD) whether work is to be performed by State personnel or by contract	50%	N/A	Plan required prior to start of work
4. Authority to proceed under §1903(a)(3)	N/A	Yes	APD
5. Request for Proposal (RFP) for design, development, installation and improvement	90%	Yes	RFP document required
6. a. Proposal evaluation and contractor selection	90%	N/A	N/A
b. Contracts for design, development, installation or improvement	N/A	N/A	Final contending proposals, selecting criteria, and proposed contract

* This task is optional.
** HCFA approval must be obtained prior to the start of this step. If threshold amounts of 45 CFR 95.601 et seq., are met, no FFP (even at the 50% rate) would be available unless the appropriate prior approval is obtained.

Task Phase/Events	FFP Matching Rate	HCFA Prior Approval	Required Submittals
7. a. System analysis, design requirements definition	90%	N/A	Periodic status reports only as requested
b. System design development, and documentation	90%	N/A	Periodic status reports only as requested
c. Installation resulting from new design and development	90%	N/A	Periodic status reports only as requested
8. Contract modifications or implementation plan changes	N/A	N/A	Modification or changes
9. System acceptance including documentation	N/A	Yes	Letter of notification from State to HCFA (See § 11241)
10. Systems improvements	90%	Yes	APD

Task Phase/Events	FFP Matching Rate	HCFA Prior Approval	Required Submittals
TO OBTAIN 75 PERCENT FFP			
1. Systems Operations (i.e., State operated, contractor operated, or may include other State departments)	75%	Yes (the certification review)	Written statement as required in §11241
2. Continuing Operations	75%	***	***
3. Systems Maintenance	75%	Yes for $100,000 or more in a year and for $200,000 or more in total Federal and State funds, and for $25,000 or more if non-competitive	written request as required in § 11227

***Adherence to the Approved System and Required Improvements

EXHIBIT 11275.2 Costs Related To State MMIS Design, Development, Installation, Operation, and MMIS Improvement

11275.21 Introduction

FFP is available at either 90 percent or 75 percent, but it may be paid only for those functions which are attributable to an MMIS. For example, with respect to provider enrollment, only the costs of entering data into the computer system and processing computer exceptions would be reimbursed at 75-percent FFP. Other functions, even if performed by the same unit or individuals, are reimbursable at 50-percent FFP. Appropriate costs, including overhead, for the direct costs attributable to the operation of the system are also payable at 90-percent or 75-percent FFP respectively.

11275.22 Attributable Costs Under 90-Percent FFP

FFP at 90 percent is available for costs directly attributable to the Medicaid program for the design, development, installation, and improvement of mechanized claims processing and information retrieval systems. Included are resources needed for systems requirements analysis, design definition, forms development, programming, unit testing, integrated test conversion, the use of hardware to the extent necessary for design, development, and installation, and supplies for the above. Also included are the personnel costs of the State project management team specifically assigned for the development and installation effort. Other administrative activities are matched at 50 percent.

11275.23 Attributable Costs Under 75-Percent FFP

FFP at 75 percent is available for costs directly attributable to the Medicaid program for ongoing automated processing of claims, payments, and reports. Included are forms, system hardware and supplies, maintenance of software and documentation, and personnel costs of operations control clerks, suspense and/or exception claims processing clerks, data entry operators, microfilm operators, terminal operators, peripheral equipment operators, computer operators, and claims coding clerks if the coded data is used in the mechanized claims processing and information retrieval system. Also such functions deemed to be part of the operation of the MMIS include analysis of exception reports generated by the MMIS. Most report users, such as staff who perform followup investigations, are not considered part of the MMIS. In addition, 75 percent is available under §1903(a)(2) as is attributable to compensation or training of skilled professional medical personnel and staff directly supporting such personnel.

FFP at the 75-percent level for operations does not cover clerical processing operations, except as indicated above. One of the aims of system improvements should be the mechanization of front-end manual editing operations to achieve greater edit reliability and the reduction of clerical workload.

11275.24 Attributable FFP and Costs at the 75-Percent Level Re: Eligibility Operations Subject to Review by the Office of Family Assistance (title IV-A of the Social Security Act)

Includes system operations costs directly attributable to Medicaid requirements. The Medicaid mechanized claims processing and information retrieval system requires an eligibility file for assuring Medicaid payments only for eligible recipients, and a data base for generating appropriate management reports. The systems effort required by the Office of Family Assistance to generate this file, consistent with the systems requirements in this guide, will be covered by FFP at the 75-percent level as follows:

o If under current operations the master eligibility file is employed for editing and information runs for both Aid to Families with Dependent Children (AFDC) and Medicaid, 75-percent matching would cover the Medicaid computer runs, but would not be available for the master eligibility file maintenance and update.

o If a shared online eligibility determination file is used, a cost allocation plan as described in §11268 is required. The cost allocation plan will specify costs directly attributable to Medicaid requirements which are matched at the 75-percent FFP rate. For those costs attributable to common program requirements and elements, the Medicaid portion will be specified in the cost allocation plan and is matchable at the 75-percent FFP rate under 1903(a)(3).

o If the Medicaid eligibility file is obtained by extraction from the AFDC eligibility file, the costs associated with this process would be covered under the 75-percent provisions. The use of this Medicaid eligibility file as a part of the MMIS is also covered under the 75-percent FFP provision.

11275.25 Attributable Costs Under 90-Percent and 75-Percent FFP For Equipment and Supplies Rented or Purchased

Purchase rather than rental of mechanized equipment must be justified by establishing that it is to the economic advantage of the State and Federal Government after consideration of the tangible and intangible factors involved. Included in this determination should be consideration of the alternative to lease the equipment with option to purchase. Purchase equipment secured for operational purposes is eligible only for FFP at 75 percent. The FFP percentage for purchase of supplies depends upon the life and use of the item. Thus, "short life" supplies to be purchased for system test and installation such as cards, microfilm, and forms (limited quantity)

may be charged at 90-percent FFP. These same items secured for operations following installation must be charged at 75-percent FFP.

"Long life" supplies purchased, such as disk packs and magnetic tapes, must be charged at 75-percent FFP since, as in the case of equipment, the intent is for use in continuous operations. (See 45 CFR Part 95 for standards for depreciation and use allowances.)

Rental costs of equipment may be charged at 90-percent FFP for test and installation, and 75-percent FFP for operations. Costs for site preparation are start-up costs for operations and matched at 75-percent FFP.

11275.26 Attributable Costs Under 75-percent FFP for SURS and MARS Staff Engaged in First-Line Review of MMIS Data

Costs directly associated with the personnel involved in the design, production, or enhancement of MARS and SURS reports qualify for 75-percent FFP. This funding is restricted to the personnel who routinely perform these functions as part of their assigned responsibilites. Users of the reports are not eligible for the enhanced FFP.

Since the SURS subsystem involves a function, unlike the MARS which is only a reporting system, a SURS unit could be included for enhanced MMIS funding. It, however, must be identifiable within the organizational structure and be involved with SURS-generated reports. This does not include the staff that reviews SURS reports within the organization beyond the defined SURS unit. As a part of the review of SURS data, it must also have the responsibility for the design or enhancement of the SURS reports. Within this function, only the review of SURS generated data is eligible for MMIS funding. Any followup investigation or provider contact is excluded.

11275.27 Attributable Costs Under 75-Percent FFP for MMIS-Related Clerical or Manual Processing Activities

Although it is an objective of the MMIS to reduce manual processing (§ 11275.23), some manual intervention is necessary to make any computer system perform properly. However, only those manual functions which are directly attributable to the operation of the MMIS will be funded at the enhanced FFP. As long as the function is one which has otherwise been done by the State (in the absence of an MMIS), the State will not receive 75-percent FFP in its expenditures for performing the function manually (just because they also have an MMIS). Manual edits which could be routinely performed by the computer are not allowable at 75-percent FFP.

Certain costs of the State agency or of the fiscal agent, which are a part of the claims processing functions but not directly attributable to the processing of claims, may be allowable. For example, the training of new key punch and operations control staff on MMIS terminology, or an internal quality control of data entry staff are allowable. Although not directly involved in the processing of claims, both activities contribute to the efficiency of the claims processing system.

11275.28 Attributable Costs Under 75-Percent FFP for Program management, Prior Authorization of Services, and Audit

The 75-percent FFP for MMIS operations is available for claims processing and information retrieval functions performed by the State agency or the fiscal agent. This includes the actual processing of claims as well as the production of MMIS reports. As such, the following functions must be reviewed in terms of their relationship to claims processing and information retrieval.

o Program Management: Although required to operate a Medicaid program, this function is not reimbursable at the MMIS FFP rate unless directly related to claims processing. For example, making a program management decision on a specific suspended claim is allowable at 75-percent FFP. However, the development and issuance of overall policy is excluded. The development of an edit for the claims processing system to implement a program policy (e.g., a limitation of a service) is allowable and includes the cost of designing and implementing the edit. The cost of the program management staff that developed the policy is excluded as part of ongoing program management.

o Prior Authorization of Services: A program management decision on a claim entered into the system and suspended is allowable. However, prior authorization of a service such as othodontics or elective surgery before the service is delivered is not allowable. Such a decision is based on limitations in the State plan and not directly related to the mechanized claims processing system.

o Audit: All State and fiscal agent audit activity is not eligible for enhanced FFP as an MMIS activity. This includes cost report audits, provider audits, and followup investigation of claims where fraud is suspected.

11275.29 Attributable Costs Under 75-percent FFP for Postage

Postage costs associated with: issuance of EOBs, issuance of ID cards, and issuance of remittance statements are allowable at the 75-percent FFP rate. Other postage costs are reimbursed at the 50-percent FFP rate.

11275.30 Attributable Costs Under 90-Percent and 75-Percent FFP for Overhead Costs

Only the direct overhead costs resulting from the operation or development of an MMIS are eligible for the enhanced FFP rates. Such costs are usually the non-personnel costs such as electricity, rent, shared facilities, caused by the operation or development of the MMIS.

Overhead costs not directly resulting from the MMIS cost center are reimbursed at the 50-percent FFP rate. Such costs are the statewide overhead (A-87) costs and the costs associated with the State agency's overhead functions (personnel staff, budget staff, legal staff, commissioner's office, etc.) assigned to the MMIS cost center through the State Agency's cost allocation plan. This applies also with respect to a fiscal agent's costs.

11275.31 Attributable Costs Under 75-percent FFP for Fiscal Agent MMIS Operations

A fiscal agent may perform many additional functions (§ 11275.28) for the State beyond those related to MMIS operations eligible for 75-percent FFP, yet bill the State at one all-inclusive rate per claim processed. If HCFA's review of the fiscal agent's contract and operations show this to be the case, the State will be required to develop a cost allocation plan through which its payments to the fiscal agent are broken out for matching at the appropriate FFP rates. (See § 11275.30.)

11275.32 List of Reimbursable Costs for State Systems

Although the functions of the Medicaid Program are addressed by the MMIS, some Medicaid operations are not part of the automated claims processing and information retrieval system. In deciding whether costs should be applied to MMIS, certain issues impinge on the decision. For the most part, the higher FFP will be granted for costs directly incurred by the approved MMIS. Regulations at 45 CFR Part 74, Appendix E define direct costs as "those that can be identified with a specific cost center" such as MMIS. "Indirect costs are those that have been incurred for common or joint objectives, and thus are not readily subject to treatment as direct costs." Costs of shared facilities (which include common computer hardware, common terminals, buildings, etc. used by the MMIS and other components) are apportioned by an approved cost allocation plan. These indirect costs, when directly attributable to the MMIS, are funded at the higher FFP from 1903(a)(3) funds.

The issue of cost allocation is a major issue in reimbursable costs. As the following chart (Page 11-2-30ff) alludes to throughout, costs must be documented in a cost allocation plan approved by the HCFA Regional Administrator. § 11268 states that "State agencies must be able to provide documentation to support wages, benefits and other expenditure items in accordance with Federal Regulations in 42 CFR 433.34." The plan must include "methods and procedures charging the costs of administration, medical assistance, and training incurred under the plan." Approval of a cost allocation plan may not automatically constitute approval of the amount of a specific expenditure. Indirect costs not directly attributable to the MMIS cost center, such as personnel, finance, etc., are funded at 50 percent.

Another important issue of funding is that of maintenance versus approved system changes. The question often turns upon a matter of degree. Maintenance is further refinement of a system but to a minimal degree. It may include a minor modification to a report or even the introduction of new software to improve the input. On the other hand, approved changes are major alterations to a system. They include new routines, major modifications to existing routines, major modifications to subsystems, or entirely new add-on subsystems. Examples of approved system changes may include installation of a Third Party Liability Subsystem, installation of the HCFA HCPCS procedure coding, installation of ICD-9 CM diagnosis coding, conversion from SURS-I to SURS-II, or Federally-mandated system requirements.

Integration is another concern. "Integration" means that the data from the subsystems must feed the MARS and SURS. Integrated systems share a common data base. The functions and operations of the major subsystems and add-on subsystems, such as TPL, EPSDT, and others, must be linked by computers, electronic media, and/or telecommunications equipment with the functions and operations of the MMIS. All subsystems must contribute to efficient, economical and effective administration of the State plan. Integration is part of this. All subsystems added on and side-payment systems, i.e., payment systems as defined in § 11225 A&B MMIS (such as a separate TPL or a separate LTC system) must feed information to the approved MMIS by automated means.

The nature of automation must be considered. "Automated" means that functions are performed by computers. Automated systems are systems in which most functions are performed by computers. Even the most automated system, one that uses machines to perform most functions, requires some manual intervention. The degree of manual intervention for an approved automated system depends upon what is efficient, economical and effective in the management of a specific State's Medicaid program. Essentially, 75-percent FFP is available for the automated functions and for the manual intervention necessary to enable the system to perform those functions.

The list provides a clearer picture of what HCFA authorizes as reasonable costs for the design, development, installation, operation, improvement, and maintenance of an automated Medicaid system. Only items identified as qualifying for 90-percent or 75-percent FFP on the list are subject to enhanced FFP as expenditures for MMIS under §1903(a)(3).

REIMBURSABLE COSTS FOR STATE SYSTEMS

Item	Subsystem (Where Applicable)	90% (With Approved APD)	75% (With Approved System)	Over 50% (Other than 1903(a)(3) Funds)	50%	Part 11	Other Ref.
THE IMPLEMENTATION PROCESS							
Feasibility Study					X	11275.1	
Advanced Planning for Increased FFP for Systems					X	11275.1	
Request for proposal for Design, Development and installation or improvement of a mechanized claims processing and information retrieval system		X				11110 11266 11275.1	
RFP to contract for an evaluation of proposals		X				11275.22	
Proposal Evaluation and Contractor Selection		X				11275.1	
Detailed State Implementation Plan		X				11110H 11275.1	
Systems Analysis, Design, and Requirements Definition		X				11110F 11275.1	
Systems Design and Development		X				11275.1	42 CFR 433.111
Systems Improvements							
a. Design, Development, and Installation		X				11225B 11275.1	42 CFR 433.111

REIMBURSABLE COSTS FOR STATE SYSTEMS

Item	Subsystem (Where Applicable)	90% (With Approved APD)	75% (With Approved System)	Over 50% (Other than 1903(a)(3) Funds)	50%	Part 11	Other Ref.
b. Operation			X			11275.1	42 CFR 433.111
Hardware Operation (only to the extent necessary for installation)		X				11275.22	
Installation Resulting from New Design and Development (includes modifications, systems improvements and add-ons)		X				11275.1	42 CFR 433.111
Systems Installation		X				11275.1 11275.22	42 CFR 433.111
Equipment Used for Test and Installation (rent cost)		X				11275.22 11275.25	
Eligibility Subsystem (if integrated)							
a. Design, Development, and Installation		X				11225 11275.1	
b. Operation (if approved)			X			11275.24	42 CFR 433.111

REIMBURSABLE COSTS FOR STATE SYSTEMS

Item	Subsystem (Where Applicable)	90% (With Approved APD)	75% (With Approved System)	Over 50% (Other than 1903(a)(3) Funds)	50%	Part 11	Other Ref.
EPSDT Subsystem (if integrated)							
a. Design, Development, and Installation		X				11225 11275.1	
b. Operation (if approved)			X			11225B 11275.1	
Long Term Care Subsystem (if integrated)							
a. Design, Development and Installation		X				11225 11275.1	
b. Operation (if approved)			X			11225B 11275.1	
Third Party Liability Subsystem (if integrated)							
a. Design, Development, and Installation		X				11225 11275.1	
b. Operation (if approved)			X			11225B 11275.1	
Systems Operation During Changeover (from termination of approved system up to approval of new system)						11275.22	

REIMBURSABLE COSTS FOR STATE SYSTEMS

Item	Subsystem (Where Applicable)	90% (With Approved APD)	75% (With Approved System)	Over 50% (Other than 1903(a)(3) Funds)	50%	Part 11	Other Ref.
a. Operation of new unit during transition to new contractor or from state operation to contractor (or vice versa) for a state-owned system. New system and old system remain same system--only operator changes.			X				
b. Operation of new system during transition from proprietary to either State-owned or proprietary system (subject to retro-active increase to 75% after approval of new system.)					X		
Implementation and installation of a system not owned by the State (All costs including contractor costs)					X	11275.22	
Subsystem Operation from End of Design and Development Phase to Approval of Operations					X	11255	
Integrated Systems Testing for MMIS		X				11275.22	
PERSONNEL, MATERIALS AND EQUIPMENT					X	11275.23 11275.30	1903(a)(7)
Automated administrative support systems (such as personnel, financial management, and the like)			X			11275.23 11275.27	
Claims Coding Clerks (if data is used in the MMIS)							

REIMBURSABLE COSTS FOR STATE SYSTEMS

Item	Subsystem (Where Applicable)	90% (With Approved APD)	75% (With Approved System)	Over 50% (Other than 1903(a)(3) Funds)	50%	Part II	Other Ref.
Claims Control Staff			X			11275.23 11275.27	
Coding clerks (MMIS)			X			11275.23 11275.27	
Computer Operators (staffing costs) (in support of the MMIS)			X			11275.23	
Contract Management Group (where system run by agent) (MMIS Systems Operations Only)			X			11275.23 11275.28	
Data Entry Operators (staffing costs)			X			11275.23	
Fiscal agents, contractors, etc. (those functions directly attributable to MMIS)			X			11275.23 11275.31	
Fraud control unit personnel (first 3 years)				X (90%)			1903(a)(6)
Fraud Control Unit Personnel (after 3 years)				X (75%)			1903(a)(6)
Hardware Operation (except for installation)			X			11275.22	
Investigative Staff and their Support Staff					X	11275.23 11275.28	1903(a)(2) 1903(a)(6)
Local ADP systems (not a State-wide operation) (such as city, county)					X	11275.23	1903(a)(7)
Maintenance of Software and Documentation			X			11275.23	

REIMBURSABLE COSTS FOR STATE SYSTEMS

Item	Subsystem (Where Applicable)	90% (With Approved APD)	75% (With Approved System)	Over 50% (Other than 1903(a)(3) Funds)	50%	Part 11	Other Ref.
							11270
Medicaid Personnel (only personnel directly attributable to MMIS operations)			X			11275.23 11275.27	
Microfilm Operators (MMIS staffing costs)			X			11275.23	
Provider Manuals					X	11275.23	
Provider Relations Manager/Receptionist							
a. Directly related to claims operations			X			11275.23	
b. Not directly related to claims operations					X	11275.23	
Provider Representatives and Related Personnel							
a. Directly related to claims operations			X			11275.23	
b. Not directly involved with claims operations					X	11275.23	
Publications necessary for installation of MMIS		X				11275.22	
Publications necessary for the operation of the system (e.g. claims forms such as HCFA-1500, UB-82)			X			11275.23	42 CFR 433.111 (Operation)

REIMBURSABLE COSTS FOR STATE SYSTEMS

Item	Subsystem (Where Applicable)	90% (With Approved APD)	75% (With Approved System)	Over 50% (Other than 1903(a)(3) Funds)	50%	Part 11	Other Ref.
Publications necessary for maintenance of Medicaid program					X	11275.23 11275.28	
Reference File/Research Microfilm and Microfiche			X			11275.23	
Shared Teleprocessing Equipment (cost allocation plan)			X			11270 11315E	
Short Life Supplies used for test and installation (e.g., cards, microfilm, and forms)		X				11275.25	
Short Life Supplies Used for Operations			X			11275.25	
Skilled Professional Medical Personnel				X (75%)		11275.23	Sec. 1903(a)(2)
Statewide overhead (A-87) costs					X	11275.30	
SURS staff engaged in first-line review of MMIS data			X			11275.23 11275.26	

REIMBURSABLE COSTS FOR STATE SYSTEMS

Item	Subsystem (Where Applicable)	90% (With Approved APD)	75% (With Approved System)	Over 50% (Other than 1903(a)(3) Funds)	50%	Part 11	Other Ref.
Suspense and/or exception claims processing clerks (staffing costs) (Only those costs associated directly with the MMIS)			X			11275.23 11275.27	
System costs for services identified in State Plan			X			11110Q	
Systems Supplies i.e. magnetic tape, cards disk			X			11275.23	
Terminal operators (MMIS staffing costs)			X			11275.23	
OTHER ACTIVITIES							
Audit					X	11275.28	
Automated Long Term Care System (If integrated)			X			11225	1903(a)(4)
BPST (bill processing systems test) (for systems maintenance)			X			11275.1 11275.23	
Consistency check	Claims Processing		X			11325B 11330E 11275.27	MMIS GSD pg. I-10 & I-12
Cost report audits					X	11275.28	

REIMBURSABLE COSTS FOR STATE SYSTEMS

Item	Subsystem (Where Applicable)	90% (With Approved APD)	75% (With Approved System)	Over 50% (Other than 1903(a)(3) Funds)	50%	Part 11	Other Ref.
EPSDT (If integrated)	Recipient or EPSDT		X			11225 11315E	
Error correction (correction of suspended claim) (as an integral part of the mechanized system)	Claims Processing		X			11325C 12275.27	MMIS GSD pg. I-10 & I-11
Exception claims processing by claims type (correction of suspended claim)	Claim Processing		X			11275.23 11275.27 11275.28	MMIS GSD pg. I-10 to I-12
External Quality Control (Such as manual sampling)					X	11275.23	
"Hot Line" requests (general information)					X	11275.23 11275.28	
Followup investigation of claims for which fraud is suspected					X	11275.23 11275.28	
Identification of claims paid for all services	Claim Processing		X			11275.23	MMIS GSD pg. I-10 to I-12
Interface between States and contractor (contract management group) (MMIS Systems Operation Only)			X			11275.23	
Internal Control Routine	Claims Processing		X			11275.23	

REIMBURSABLE COSTS FOR STATE SYSTEMS

Item	Subsystem (Where Applicable)	90% (With Approved APD)	75% (With Approved System)	Over 50% (Other than 1903(a)(3) Funds)	50%	Part 11	Other Ref.
Issuance of checks and postage	Claims processing				x	11275.29	
Issuance of EOB and postage	Claims Processing		x			11275.29 11325C3	MMIS GSD pg. I-12
Issuance of ID cards and postage	Recipient & Provider		x			11275.29 11315A 11320D	MMIS GSD pg. I-15
Issuance of remittance statements and postage	Claims Processing		x			11275.29 11325C2	MMIS GSD pgs. I-11 & I-12
Liaison between State and contractor (systems liaison)			x			11275.23	
Maintenance of data necessary to support claims processing	Reference file Recipient, Provider Eligibility, TPL, etc.		x			11275.24 11315A 11320E 11325G 11330B	MMIS GSD pg. I-12
Medicaid recipient automated eligibility file (Categorically needy and medically needy) (the process to extract the data)	Recipient		x			11270 11275.24AorC	MMIS GSD pg. I-15
Microfilming Claims			x			11275.23	
Monitoring of the contractor (State or contractor) (MMIS Systems Operations Only)			x			11275.23 11275.28	

REIMBURSABLE COSTS FOR STATE SYSTEMS

Item	Subsystem (Where Applicable)	90% (With Approved APD)	75% (With Approved System)	Over 50% (Other than 1903(a)(3) Funds)	50%	Part 11	Other Ref.
Online eligibility system	Recipient						
a) Costs directly attributable to Medicaid requirements			X			11275.24B 11315D	
b) Share of Costs attributable to common program requirements (Cost Allocation Plan)			X			11275.24 11275.28A	
Payment of Claim (including production of check or warrant)	Claims Processing		X			11325	MMIS GSD pg. I-10 -I-12. pg. I-16
Program Integrity - (Medicaid) Investigation (Initial 3-year period for unit)				X (90%)			1903(a)(6)
Program Integrity Investigation (Medicaid) (after initial 3 year period)				X (75%)			1903(a)(6)
Production of Program Management Information necessary to satisfy Federal reporting requirements	MARS		X			11340C	MMIS GSD pages I-13 & I-14
Production of reports to meet needs of title XIX managers, PROs and State Medicaid fraud control units	S/URS &MARS		X			11335B 11340B	MMIS GSD pg. I-13
Provider audit					X	11275.28	

REIMBURSABLE COSTS FOR STATE SYSTEMS

Item	Subsystem (Where Applicable)	90% (With Approved APD)	75% (With Approved System)	Over 50% (Other than 1903(a)(3) Funds)	50%	Part 11	Other Ref.
Provider Enrollment (actual enrolling)							
a) Training of the provider	Provider		X			11320B	MMIS GSD III-1
b) Keying and activities for maintenance of provider records			X			11320D	MMIS GSD III-1
Provider Validation (automated and integrated)	Provider		X			11320C	MMIS GSD I-10&I-15
Query for eligibility of (provider or recipient) (automated and integrated)	Claims Processing		X			11325A	MMIS GSD pg. I-11
State Buy-In (automated and integrated)	Recipient		X			11315A	MMIS GSD pg. I-16 & pge II-3 to II-4
SURS reports							
a) Staff engaged in analyzing data coming out of MMIS and formulating a corrective plan of action	SURS		X			11275.23 11275.26	
b) The staff who perform follow-up investigations					X	11275.23 11275.26	42 CFR 432.50 b(2) &b(6)
Systems Integrity - Internal Audit (for systems maintenance) **(MMIS Systems Operation Only)**			X			11275.23 11275.28	

REIMBURSABLE COSTS FOR STATE SYSTEMS

Item	Subsystem (Where Applicable)	90% (With Approved APD)	75% (With Approved System)	Over 50% (Other than 1903(a)(3) Funds)	50%	Part 11	Other Ref.
Third Party Liability (automated and integrated)	Recipient & Claims Processing		X			11275.27 11315F	MMIS GSD pg. II-11.1
Training							42 CFR 432.50
a. For skilled medical personnel and supporting administrative staff				X (75%)			
b. For personnel engaged in the operation of the mechanized claims processing and information retrieval system			X				
c. For personnel engaged in the design, development, and installation of the mechanized claims processing and information retrieval system							
1. Training Costs					X		
2. Salary or other compensation, fringe benefits and per diem		X					
d. For personnel administering family planning services and supplies				X (90%)			
e. For all other staff of the Medicaid agency					X		

EXHIBIT 11275.5 Effective Date of Part 11

On February 28, 1983, the Departmental Grant Appeals Board (GAB) in decision number 395 specifically stated that "there is no indication from the language of the State Medicaid Manual (1982), that it was meant to be applied retroactively to prior claims." The GAB stated that Transmittal 2 of Part 11 was effective for Federal funding purposes with the date of issuance--February 1, 1982. Similarly, Transmittal No. 1 of Part 11 was effective with the date of its issuance--July 1, 1981. Prior to July 1, 1981, specific funding guidance for MMIS expenditures was found in PRG-31.

For the most part, PRG-31 and Part 11 of the State Medicaid Manual are identical in regard to funding guidelines. Where differences exist, the date the expenditure was incurred determines the applicable funding guidelines (PRG-31 vs. Part 11). Examples of substantive changes in funding guidelines include:

Cost Item	Part 11 FFP Rate	PRG-31 FFP Rate
RFP for design, development, installation, and improvement	90 percent	50 percent
Proposal evaluation and contractor selection	90 percent	50 percent
Detailed State implementation Plan (whether work is to be performed by State personnel or by contract)	50 percent	N/A
RFP to contract for an evaluation of proposals	90 percent	N/A

SYSTEM REQUIREMENTS

CHAPTER 3

	Section	Page
General Requirements	11300	11-3-3
Future Additional System Requirements	11301	11-3-4
MMIS-GSD Functional Requirements	11310	11-3-4
Recipient Subsystem	11315	11-3-5
Provider Subsystem	11320	11-3-5
Claims Processing Subsystem	11325	11-3-6
Reference File Subsystem	11330	11-3-8
Surveillance and Utilization Review Subsystem	11335	11-3-9
Management and Administrative Reporting Subsystem	11340	11-3-10
Exhibits	11375	11-3-12

11300 GENERAL REQUIREMENTS

A. The system requirements in §§11300 through 11375 are intended as a basis for the improvement of title XIX programs in the mechanization of claims processing and information retrieval systems. These requirements will be used with other requirements in Chapter 2 by HCFA as a basis for determining whether the proposed system or existing system qualifies for 90-percent or 75-percent Federal funding. Federal MMIS requirements are to be considered minimal, not exclusive requirements.

The intent of §1903(a)(3) is the improvement of title XIX programs through Federal assistance in the mechanization of approved Medicaid claims payment and information systems. To accomplish this and still allow for necessary variations among the States, HCFA has determined that MMIS-GSD is the most generally available total system design satisfying the requirements of §1903(a)(3) which can be used as a model for new systems and a measure of existing systems. Accordingly, HCFA will use as its standard for evaluation of systems for which funding is requested under §1903(a)(3), the version of the MMIS-GSD on file with the National Technical Information Service (NTIS) of the Department of Commerce (see Exhibit §11375.2) at the time of approval of funding under the provisions of 42 CFR 433.112. For States requesting certification of systems not funded under the provisions of 42 CFR 433.112, HCFA will use the version of the MMIS GSD which is in effect at the time certification is requested. The MMIS-GSD requirements and other future requirements will be added to the NTIS MMIS documentation through updates. Recognizing that variations in the expression and/or implementation of identical concepts are not necessarily detrimental, HCFA will be guided by a policy of "demonstrable conceptual equivalence" as defined in §11110 when evaluating systems differing from the MMIS-GSD.

HCFA will be further guided by the principle of avoiding duplicate systems design and development costs whenever possible by requiring the transfer of existing designed, developed, and/or installed approved systems in situations where the feasibility of a successful transfer is assured.

B. To receive HCFA approval for funding under 42 CFR 433, an existing or proposed system must:

- Be mechanized;
- Include or encompass all subsystems;
- Conform in concept with each subsystem describe herein;
- Provide security from anticipated threats or hazards to its data;
- Maintain a record of every query directed against an individual's record, including the identity of the person or organization originating that query;
- Be able to eliminate from the system data which is no longer timely;

- o Contain and utilize the data elements described in Exhibit 11375.1;
- o Provide and apply the following minimum edits to all input data regardless of how such data enters the system;

  proper field content,

  accuracy of data, and

  reasonableness of data

- o Produce and disseminate in a timely and accurate manner all systems reports.

***o Accept and use exclusively a common hospital billing form (i.e., the Uniform Bill (UB-82), (Standard Form HCFA-1450)).

***o Accept the same provider electronic billing data set required by the Medicare program.

****o Accept and use exclusively the common claim form for non-institutional providers (physicians, durable medical equipment suppliers, laboratories, chiropractors, and podiatrists). This form is the Health Insurance Claim Form, HCFA-1500 (currently the 1-84 version).

11301 FUTURE ADDITIONAL SYSTEM REQUIREMENTS

When HCFA determines that additions or changes will improve the Medicaid claims processing and information retrieval system, HCFA will publish these changes by notice in the Federal Register making the proposed change available for public comment. After allowing an appropriate period, HCFA will respond to the comments received in a subsequent notice. When the final notice is published, HCFA will issue the new or modified standards or conditions in the SMM. Based upon the requirement's complexity, HCFA will allow the States an appropriate time period to meet the new requirement.

11310 MMIS-GSD FUNCTIONAL REQUIREMENTS

The MMIS-GSD is designed to meet the objectives in §11115. The MMIS-GSD presently consists of the following subsystems (additional subsystems will be published):

- o Recipient
- o Provider
- o Claims Processing
- o Reference File
- o Surveillance and Utilization Review
- o Management and Administrative Reporting

***States must have implemented this system requirement by January 1, 1986.
****States must implement this new system requirement by October 1, 1986.

11315 RECIPIENT SUBSYSTEM

A. The recipient subsystem must accomplish objectives and functions equivalent to those contained in Volume I, Section II of the MMIS GSD. The principal objectives include the following:

- o Maintain identification of all applicants eligible for Medicaid benefits.
- o Provide timely updating of the Medicaid Eligibility Master File to include new recipients and all changes to existing recipient records.
- o Maintain positive control over all data pertaining to Medicaid recipient eligibility.
- o Build and maintain a computer file of recipient data to be used for claims processing, administrative reporting, and surveillance and utilization review.
- o Distribute eligibility data to other processing agencies, if a requirement exists.
- o Maintain control over the Medicare Part B Buy-In processing for eligible recipients.

B. The system must receive appropriate Medicaid recipient eligibility data from all sources of eligibility determination.

C. The system must provide file space for, and record whenever available, the Social Security Number of each eligible recipient.

D. A shared on-line recipient subsystem must provide Medicaid data and reports as required by the Medicaid Agency.

E. If the EPSDT system is integrated into the MMIS then case identification, tracking, and referral functions will be performed as part of the recipient subsystem.

F. The subsystem will contain and use the data necessary to support third party liability recovery activities.

11320 PROVIDER SUBSYSTEM

The State's provider subsystem must accomplish objectives and functions equivalent to those contained in Volume I, Section III of the MMIS GSD. The principal objectives include the following;

A. Encourage the participation of qualified providers in the Medicaid program.

B. Enroll providers in the Medicaid program after they agree to abide by the rules and regulations of the State program.

C. Ensure that providers are qualified to render specific services under the Medicaid program by screening applicants for State license and certification, by Specialty Board certification if appropriate, and by visit to the provider by a review team if necessary.

D. Process provider applications and changes in a timely manner and maintain control over all data pertaining to provider enrollment.

E. Build and maintain a computerized file of provider data to be used for invoice processing, administrative reporting, and surveillance and utilization review.

F. Review enrolled providers on a continuing basis to ensure that they continue to meet provider eligibility requirements.

11325 CLAIMS PROCESSING SUBSYSTEM

A. The claims processing subsystem must accomplish objectives and functions equivalent to those contained in Volume II, Section IV of the MMIS GSD. The principal objectives include the following;

- Ensure that all input into the subsystem is captured at the earliest possible time and in an accurate manner.
- Establish control over all transactions during their entire processing cycle.
- Verify that all providers submitting input are properly enrolled.
- Ensure that all recipients for whom input is submitted were eligible for the type of service at the time the service was rendered.
- Ensure that all input submitted to the subsystems is processed completely.
- Verify that charges submitted by providers are reasonable and within acceptable limits.
- Ensure that reimbursements to providers are rendered promptly and correctly.
- Maintain accurate and complete registers and audit trails of all processing.
- Maintain all processed data necessary to satisfy legal requirements and the needs of other subsystems.
- Respond to queries concerning recipient eligibility and benefit status.
- Process approved prior authorization requests.

- o Process provider credits and adjustments.

B. Techniques will be implemented to perform the following:

- o Identify uniquely and locate any provider claim.
- o Automatically suspend all transactions in error until corrections are made.
- o Check each claim prior to payment against all current and previously paid claims for which a duplicate payment could exist.
- o Provide a prompt response to all inquiries regarding the status of any claim.

C. The claims processing subsystem will be designed to assure:

- o Adjudication for payment within 30 days after:

  receipt of any properly submitted correct claim which passes all required edits and checks; or,

  correction of any error condition(s) preventing payment which are attributable to the provider; or,

  correction of any error condition(s) preventing payment which are attributable to the agency or its system or its data; or,

  correction of any condition(s) preventing payment which are beyond the agency's control.

- o Issuance of remittance statements to providers detailing claims and services covered by a given payment at the same time as the payment.

- o Provide EOB individual notices, within 45 days of the payment of claims, to all or a sample group of the persons who received services under the plan as described in §11210. To assist MMIS States in implementing the option to send EOBs on a sample basis, the following sampling methods are recommended:

  Sampling instructions are the Medicaid fraud guidelines on Verification of Services to Recipients. They provide for a sample of claims from high-volume providers and a sample of claims from low-volume providers. Sample sizes may be increased or decreased each month at State discretion. Note that each sample only represents each set of providers, not all claims paid.

  One random sample from all claims a State pays each month. It should be large enough to obtain some overall representation of the population: at a minimum, a monthly sample ranging from 500 claims

up to 100% of the State population. The distribution of claims in such a sample will tend to mirror that of the population, including many drug and doctor claims and relatively few hospital and nursing home claims.

A random sample of providers, then a sample of claims from each of the sampled providers. The sample of providers can be structured several ways; e.g., a specified number of each type of provider, or a random sample from all providers. A minimum sample of 100 providers each month, with at least five claims sampled from each provider, is suggested.

A random sample of recipients (or cases) with all claims paid in a month for each. This method would provide the most comprehensive list of services for each sampled recipient (or case). A sample of at least 400 recipients each month is suggested. States may structure the recipient sample according to their needs -- either a random sample of recipients, or a specified number of each type of recipient (AFDC, SSI, medically needy, etc.)

States may utilize other sampling methods if approved by the HCFA Regional Administrator.

D. The claims processing subsystem will identify claims paid for all services covered by the State plan, including:

- Early and Periodic Screening, Diagnosis, and Treatment
- Family Planning Services
- Medicare deductibles and coinsurance paid by Medicaid.

E. The claims processing subsystem will ensure that the payment for services is consistent with 42 CFR 447 - Payments for Services.

F. The claims processing subsystem must have the capability to identify by recipient, the screening and related diagnosis and treatment services.

G. The claims processing subsystem must have the ability to identify TPL and assure that the title XIX program is the payor of last resort.

11330 REFERENCE FILE SUBSYSTEM

A. The reference file subsystem must accomplish objectives and functions equivalent to those contained in Volume II, Section V of the MMIS GSD. The principal objectives include:

- Provide an updating facility for the model system Procedure, Diagnosis, and Formulary File.

- o Provide a means of obtaining various listings of the Procedure, Diagnosis, and Formulary File.
- o Provide a reasonable and customary charge file for Medicaid charges, Medicare charges, or both.
- o Enable the reasonable and customary charge file to be updated.
- o Provide a means of transferring history records used for duplicate claims detection from an active file to a file used only periodically.
- o Generate various listings of the claims processing suspense file.

B. The reference file subsystem must maintain the data necessary to support the claims processing subsystem in ensuring that claims are paid in accordance with 42 CFR Part 447 -Payment for Services.

11335 SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM

A. The Surveillance and Utilization Review (SUR) subsystem must accomplish objectives and functions equivalent to those contained in Volume III, Section VI of the MMIS GSD. The principal objectives include the following:

- o Develop, over time, a comprehensive statistical profile of health care delivery and utilization patterns established by provider and recipient participants in various categories of services authorized under the Medicaid program.
- o Investigate and reveal misutilization of the State's Medicaid program by individual participants and promote correction.
- o Provide information which reveals and facilitates investigation of potential defects in the level of care and quality of service provided under the Medicaid program.
- o Accomplish the above objectives utilizing a minimum level of manual clerical effort and a maximum level of flexibility with respect to management objectives of the State's Medicaid program.

B. The SUR subsystem, by means of computerized exception processing techniques, will provide the ability to perform analyses and produce reports which are responsive to the changing needs of title XIX managers, PROs, and State Medicaid fraud control units.

C. The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

D. The following functions will be supported by the SUR reports, if required by the State Plan.

- o The capability to perform exception processing.
- o At least 9 months of adjudicated claims data in the SUR History file, of which a full 6 months or more must be used for exception processing.
- o The capability to separate Federally-assisted program participants from any others in the claims data.
- o A technical and user training program.
- o The capability to generate SUR reports and special reports as needed; including, a required annual run of all reports for all participants.
- o The flexibility to produce claim detail and special reports by provider and recipient.
- o The capability to perform focused review.
- o The capability to profile group practices and to profile each individual within the group practice.
- o The capability to suppress (ie., not generate or print) processing on individuals within a category of service or class group on a run-to-run basis.
- o Capability to access all data elements required by this chapter.

11340. MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM

A. The Management and Administrative Reporting Subsystem (MARS) must accomplish the following objectives. The MMIS GSD offers one example of MARS reports or States may use their own reporting formats and/or ad hoc reports.

- o Report information to assist management in fiscal planning and control.
- o Provide information required in the review and development of medical assistance policy and regulations.
- o Monitor the progress of claims processing activity and provide summary reports which reflect the current status of payments.
- o Review provider performance to determine the adequacy and extent of participation and service delivery.
- o Report recipient participation in order to analyze usage and develop more effective programs.

B. The MARS will be kept responsive to State users requests for information according to State defined timeframes and priorities.

C. The subsystem must produce program data necessary to satisfy Federal Medicaid reporting requirements, for example Part 2 of the SMM.

D. The following functions will be supported by the MARS reports, if required by the State Plan.

- o Prepare budget allocations for various categories of service for the fiscal year.
- o Project the cost of program services for future periods from past experience.
- o Compare current cost with previous period cost to analyze current cashflow.
- o Compare expenditures with budget to control financial position.
- o Analyze areas of expenditure for services to determine relative cost benefit.
- o Review services used by recipient categories for participation and relative cost.
- o Analyze Medicare Buy-In and Crossover claims.
- o Review provider participation and capacity with respect to recipients served.
- o Present claims processing and payment information for determination of timely reimbursement.
- o Review frequency of provider and other claims processing errors.
- o Monitor third party collections in accordance with State plan requirements.
- o Provide information needed for institutional and capitation rate setting.
- o Analyze provider claim filing for timeliness, fiscal controls, and ranking.
- o Analyze individual drug use for cost and abuse.
- o Present geographic analysis of expenditures and recipient participation.
- o Provide information to support Federal reporting requirements.

11375 EXHIBITS

Exhibit 11375.1 Data Requirements
Exhibit 11375.2 MMIS-GSD-NTIS Price List

EXHIBIT 11375.1 DATA REQUIREMENTS

The minimum data element file requirements for systems approval derive from State plan requirements and Federal reporting requirements. Data elements related to services not covered in the State plan need not be included.

Claim format and content varies depending upon the type of provider that submits a claim and individual State plan requirements.

The Uniform Hospital Discharge Data Set (UHDDS), developed through the National Committee on Vital and Health Statistics (NCVHS) and required by HHS departmental policy, effective January 1, 1975, and which meets current PRO requirements of §11205, contains, for hospital service only, discharge data as a file requirement and is identified in this section as:

* UHDDS as well as MMIS requirement
** UHDDS requirement only

The following data elements contained in the systems files are minimal and not exclusive requirements for source and use within the MMIS.

1. Recipient Identification Number:
A number that uniquely identifies an individual eligible for Medicaid benefits.

*2. Recipient Social Security Number:
The number used by SSA throughout a wage earner's lifetime to identify earnings under the Social Security program.

For newborns and children not having a SSN but covered under Medicaid, the recipient I.D., use #1 above.

3. Recipient Social Security Claim Number:
The number assigned to an individual by the SSA under which monthly cash benefits (and Medicare benefits) are paid or eligibility is established.

4. Recipient's Name:
The name of the recipient.

* UHDDS as well as MMIS requirement

84. Allowable Procedure Payment:
The maximum allowed amount payable for a particular medical procedure, treatment, or service item.

85. Professional Fee:
The amount allowed to a dispenser of drugs as compensation for his professional services.

86. Prescription Number:
The number assigned by a pharmacist to a prescription at the time it is filled.

87. Procedure Codes:****
Codes identifying medical procedures (i.e. accept and use exclusively the HCPCS in a physician or outpatient setting). (For an inpatient setting, ICD-9 CM Vol. 3 is recommended).

**a. Principal Significant Procedures:
When more than one procedure is reported, designate the principal procedure. In determining which of several procedures is the principal, apply the following criteria:

(1) The principal procedure is the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes, or was necessary to take care of a complication.

(2) The principal procedure is that procedure most closely related to the principal diagnosis.

**b. Other Significant Procedures:

(1) One which carries an operative or anesthetic risk, requires highly trained personnel, or requires special facilities or equipment.

(2) Up to four significant procedures can be reported.

(HCFA requires the acceptance of ICD-9-CM coding.)

88. Drug Code:
Codes identifying particular drugs; e.g. National Drug Code, drug tables.

****States must implement this new system requirement by October 1, 1986.
**UHDDS requirement only

89. Diagnosis Code:***
A table of codes identifying medical conditions; i.e., ICD-9-CM.

90. Drug Name:
The generally accepted nomenclature for a particular drug.

91. Drug Classification:
The therapeutic group in to which a drug is categorized.

92. Minimum Days Supply of Drugs:
The minimum units of a drug prescription eligible for payment.

93. Maximum Days Supply of Drug:
The maximum units of a drug prescription eligible for a particular drug.

94. Procedures Names:
The generally accepted nomenclature for medical, surgical, dental, etc., procedure.

95. Diagnosis Name:
The generally accepted nomenclature for a diagnosis. Name is required only if not encoded by provider. (See Data Element #61).

96. Unit of Measure:
The unit in which a drug is dispensed (e.g., cc, capsule, tablet).

97. Drug Cancellation Date:
The date after which a particular drug is no longer covered under the State Medicaid program.

98. Medicaid Reasonable Charge:
Payment amount recognized as the reasonable charge for Medicaid.

99. Discharged Patient's Destination:
A code indicating a recipient's destination upon discharge from a medical institution.

*Disposition of Patient:
a. discharged to home (routine discharge).

***States must have implemented this system requirement by January 1, 1986.
*UHDDS as well as MMIS requirement

b. Left against medical advice.
c. Discharged to another short term hospital.
d. Discharged to a long term care institution.
e. Died.
f. Other.

100. Billing Date:
The date a provider indicates a claim was prepared.

101. Procedure Charge:
The charge for an individual procedure, treatment, or service item as submitted by the provider.

102. Drug Charge:
The charge submitted by a provider for a given drug prescription.

103. Adjustment Amount:
The amount (plus or minus) by which a provider's account is to be changed.

104. Date Claim Received:
The date on which a claim transaction is received by the claims processing agency.

105. Date of Surgery:
The date on which a surgical procedure(s) was performed on an inpatient.

106. Drug Wholesale Cost:
The generally accepted wholesale cost of a drug.

107. Maximum Allowed Price:
The maximum amount that will be paid for a procedure, treatment, or service item.

108. Valid Sex Indicator:
A code which indicates when a procedure or diagnosis is limited to one sex only.

109. Age Range Indicator:
A code which specifies an age range when a procedure of diagnosis is limited to a particular age group.

110. Budgeted Amount:
The planned expenditures for various Medicaid services over a given period of time.

111. Screening Results Code:
A code indicating the outcome of the various screening tests rendered.

112. Screening Referral Code:
A code indicating the nature of any referrals made as a result of screening.

113. Screening Related Treatment:
A code identifying procedures or services received as a result of screening.

114. Family Planning Code:
A code indicating whether any diagnosis, treatment, drugs, supplies, and devices, conseling service, or other billed services or materials are for the purposes of family planning.

115. Certification Review Indicator?
Indicator showing that review was made of certification of a recipient who has been admitted to institutional care including approval status.

116. Certification/Recertification Date:
The date of certification/recertification of a recipient who has been admitted to institutional care.

117. Certification Status:
An indication of initial certification status of a patient in an institution.

118 Number of Requests for Extension:
The number of times an extension of certification of stay was requested for a patient in an institution.

119. Days Certified Initially:
The number of days stay certified initially for a patient in an institution.

120. Total Days Certified:
The total number of days stay certified for a patient in an institution.

121. Date of Application:
The date that a recipient applied for eligibility status in the Medicaid program.

11375.2 MMIS-GSD-NTIS PRICE LIST EXHIBIT 11375.2

Publications listed below are available from National Technical Information Service (NTIS) of the Department of Commerce, and should be ordered from:

National Technical Information Service
5285 Port Royal Road
Springfield, Virginia 22151

Each volume is also available in microfiche form at $3.50 per volume. Both accession number and title must appear on NTIS orders. Prepayment is faster. Billing orders require a purchase order and a charge of $5.00 per billing.

Medicaid Management Information System. General System Design for Title XIX	PB-236-550-Set	$50.50
Volume I-Recipient Subsystem and Provider Subsystem	PB-236-551	$20.00
Volume II-Claims Processing Subsystem and Reference File Subsystem	PB-236-552	$18.50
Volume III-Surveillance and Utilization Review Subsystem	PB-236-553	$21.50
Volume IV-Management and Administrative Reporting Subsystem	PB-236-554	$20.00
Volume V-Appendix: Glossary and Data Element Dictionary	PB-236-555	$23.00
Set including: PB-216-158,PB-216,159, PB216-160, PB216-157-Set		$28.00
S/UR Operational Techniques	PB-216-158	$20.00
MARS Operational Techniques	PB-216-159	$17.00
Linkage Between the General Systems Design (GSD) and the Ohio MMIS Detail System Design	PB-216-160	$39.50
Model Training Program for Implementing the Medicaid Management Information System	PB-217-222	$12.50
General Installation Guide for Title XIX Medicaid Management Information System	PB-210-742	$8.00

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best copy available

Medicaid Management Information System Detail Systems Design Specifications for the State of Ohio (Complete Set) Magnetic Tape	PB-229-681	$360.00
Section I - Introduction, Section II - Recipient Subysystem	PB-229-682	$24.50
Section III - Provider Subsystem	PB-229-683	$23.00
Section IV - Claims Processing Subsystem	PB-229-684	$51.50
Section V - Reference File Subsystem	PB-229-685	$30.50
Section VI - Management and Administrative Review Subsystem	PB-229-686	$47.00
Section VII - Surveillance and Utilization Reporting Subsystem	PB-229-687	$40.00
Medicaid Management Information System Computer Source Programs for the State of Ohio	PB-229-688	$300.00
Magnetic Tape: Source Programs		
Magnetic Tape: COBOL Copy Library Entries		

MMIS SYSTEM PERFORMANCE REVIEW (SPR)

CHAPTER 4

	Section	Page
Background and Authority	11400	11-4-3
SPR - Basic Purpose	11405	11-4-3
SPR Performance Standards	11420	11-4-3
Standard 1 - Eligibility	11420.1	11-4-3
Standard 2 - Support Files	11420.2	11-4-3
Standard 3 - Orderly/Timely Claims Processing	11420.3	11-4-4
Standard 4 - Accurate Claims Processing and Review	11420.4	11-4-4
Standard 5 - MARS	11420.5	11-4-4
Standard 6 - S/URS	11420.6	11-4-4
Standard 7 - MMIS Administration	11420.7	11-4-5
Standard 8 - Third Party Liability	11420.8	11-4-5

11400. BACKGROUND AND AUTHORITY

Section 1903(r) of the Act provides an explicit basis for developing and applying performance standards to previously approved Medicaid Management Information Systems (MMIS). It requires HCFA to conduct standards-based reviews at least once every 3 years and to use the results of those reviews as the determining factor for reapproval/disapproval of a State's MMIS and any resultant reductions in FFP levels. The reviews are integrated, to the extent practicable, into the overall State Medicaid program administration.

11405. SYSTEM PERFORMANCE REVIEW (SPR) - BASIC PURPOSE

The basic purpose of the SPR program for MMIS is to improve the effectiveness and efficiency of the Medicaid program on an individual State basis and for the program overall. Performance evaluation is based on the concept that an MMIS must meet specific functional requirements, as well as certain performance standards. Thus, the evaluation system applies measures which enable determinations to be made as to whether a State system satisfies the functional requirements and statistical levels of output relating to accuracy and timeliness. Initial approval of a State's MMIS does not guarantee automatic reapproval. The reapproval process begins anew each fiscal year and is intended to measure sustained performance, as opposed to the capabilities assured by the initial approval review. Regional offices (ROs) conduct the SPR utilizing a standard format. The current performance standards and elements appear below. States are evaluated against these standards and elements through criteria distributed to all States at least one calendar quarter prior to the start of the Federal fiscal year review period.

11420. SPR PERFORMANCE STANDARDS

The performance standards enumerated in §§11420.1-11420.8 cover the basic requirements of eligibility, support files, claims processing and review, MARS, S/URS, general administration, and Third Party Liability (TPL). The concept of demonstrable conceptual equivalence is used in assessing State performance and adherence to established system requirements.

11420.1 STANDARD 1 - ELIGIBILITY.—An Accurate System of Recipient Eligibility Information Must Be Provided.

A. ELEMENT A.—THE STATE MUST MAKE ACCURATE ELIGIBILITY DETERMINATIONS AND MUST BE RESPONSIVE TO PROVIDER REQUESTS FOR RECIPIENT ELIGIBILITY INFORMATION.

B. ELEMENT B.—THE STATE MUST MAINTAIN ACCURATE AND ADEQUATE FILES ON ELIGIBLE RECIPIENTS.

11420.2 STANDARD 2 - SUPPORT FILES.—An Accurate and Accessible System of Files Must Be Provided to Support System Operations.

A. ELEMENT C.—ACCURATE AND ADEQUATE FILES MUST BE MAINTAINED ON ELIGIBLE PROVIDERS.

B. ELEMENT D.—ACCURATE PRICING FILES MUST BE MAINTAINED FOR READY ACCESS IN SYSTEM OPERATIONS.

11420.3 STANDARD 3 - ORDERLY/TIMELY CLAIMS PROCESSING.--Claims Must Be Processed In An Orderly and Timely Manner From Initial Receipt Through Issuance of Claims Determinations.

NOTE: For purposes of Standard 3, the date of receipt is operationally defined as a date not later than the date of the first workday following the day of actual mailroom receipt. In addition, for SPR purposes electronic media claims (EMCs) are defined as claims submitted on magnetic tape, floppy disc, cassette, etc., or by transmission from remote terminals and CPUs.

A. ELEMENT E.--CLAIMS MUST BE CONTROLLED FROM RECEIPT THROUGH FINAL DISPOSITION, WITH TIMELY ISSUANCE OF COMPLETE CLAIMS DETERMINATION NOTICES.

B. ELEMENT F.--CLAIMS MUST BE PROCESSED ON A TIMELY BASIS.

11420.4 STANDARD 4 - ACCURATE CLAIMS PROCESSING AND REVIEW.--Claims Data Must Be Accurately Processed and Reviewed.

A. ELEMENT G.--CLAIMS DATA MUST BE PROCESSED ACCURATELY.

B. ELEMENT H.--SYSTEM OPERATIONS MUST APPROPRIATELY INCORPORATE EDITS AND SCREENS.

11420.5 STANDARD 5 - MARS.--A Management and Administrative Reporting Subsystem (MARS) Must Be Efficiently and Effectively Operated In Order to Provide Support to Management Review, Evaluation and Decision-Making Processes.

A. ELEMENT I.--REQUIRED FEDERAL REPORTS MUST BE ACCURATE, COMPLETE, AND RECEIVED TIMELY BY THE REGIONAL OFFICE.

B. ELEMENT J.--THE STATE MUST UTILIZE THE CAPABILITIES OF MARS TO EFFECTIVELY MANAGE AND CONTROL THE MEDICAID PROGRAM AND PRODUCE REQUIRED REPORTS WHICH ARE ACCURATE, COMPLETE, AND RECEIVED TIMELY.

11420.6 STANDARD 6 - S/URS.--The Operation of a Surveillance and Utilization Review Subsystem (S/URS) Must Provide Comprehensive Health Care Delivery and Utilization Data for Program Management, Reveal Potential Defects in the Quality of Care, and Reveal Suspected Instances of Provider or Recipient Fraud or Abuse.

A. ELEMENT K.--AN APPROPRIATE ON-GOING REVIEW OF SERVICE DELIVERY AND UTILIZATION PATTERNS MUST BE MAINTAINED.

B. ELEMENT L.--THE STATE MUST PRODUCE SERVICE DELIVERY AND UTILIZATION DATA TIMELY AND ACCURATELY IN SUPPORT OF PROGRAM ADMINISTRATION.

C. ELEMENT M.--THE CAPABILITIES OF S/URS MUST BE UTILIZED TO AID IN PROGRAM MANAGEMENT AND SYSTEM IMPROVEMENT.

11420.7 STANDARD 7 - MMIS ADMINISTRATION.—Overall Effectiveness in Carrying Out MMIS Administrative Responsibilities Must Be Demonstrated.

A. ELEMENT N.—PRUDENT AND EFFECTIVE SYSTEM MANAGEMENT MUST BE PROVIDED.

B. ELEMENT O.—ADEQUATE INTERNAL SYSTEM INTEGRITY AND SAFEGUARDS FOR INFORMATION ON RECIPIENTS SHOULD BE ASSURED.

11420.8 STANDARD 8 - THIRD PARTY LIABILITY.—An Efficient And Effective Mechanized Claims Processing And Information Retrieval System Capable Of Recovering, Controlling And Utilizing Claims And Third Party Liability Data And Accounting For Dollar Amounts To Assure That The Title XIX (Medicaid) Program Is The Payor Of Last Resort Must Be Provided.

A. ELEMENT P.—THE STATE MUST COLLECT, IDENTIFY AND INPUT THIRD PARTY RESOURCES DATA INTO THE MECHANIZED CLAIMS PROCESSING INFORMATION RETRIEVAL SYSTEM.

B. ELEMENT Q.—THE SYSTEM MUST ACCURATELY UTILIZE THIRD PARTY RESOURCE DATA TO COST AVOID CLAIMS WHEN APPROPRIATE AND THE SYSTEM MUST ACCURATELY ACCOUNT FOR THE NUMBER OF CLAIMS AND DOLLAR AMOUNTS THAT HAVE BEEN COST AVOIDED AND ANY REMAINING DOLLARS AMOUNTS THAT HAVE BEEN PAID BY THE MEDICAID AGENCY.

C. ELEMENT R.—THE SYSTEM MUST ACCURATELY UTILIZE THIRD PARTY DATA TO SEEK RECOVERY OF REIMBURSEMENT AND THE SYSTEM MUST ACCURATELY ACCOUNT FOR THE NUMBER OF CLAIMS AND DOLLAR AMOUNTS THAT ARE ACTUALLY RECOVERED.

D. ELEMENT S.—THE STATE MUST HAVE A CURRENT AND UPDATED SET OF ADMINISTRATIVE GUIDELINES AND PROCEDURES IN PLACE TO ASSURE THAT THIRD PARTY RESOURCES ARE IDENTIFIED AND PURSUED WHENEVER POSSIBLE AND TO ASSURE THAT THE MEDICAID PROGRAM IS THE PAYOR OF LAST RESORT.

CPAS REVIEW PROCESS

CHAPTER 6

	Section	Page
Background	11600	11-6-3
Overview of CPAS	11601	11-6-3
Mandatory System	11604	11-6-6
Scope	11604.1	11-6-7
Claims Not to be Reviewed	11604.2	11-6-9
Review Completion and Reporting Requirements	11604.3	11-6-9
Review Procedures	11604.4	11-6-10
Data Needs and Source Documents	11604.5	11-6-12
Development and Error Determination	11604.6	11-6-14
Error Category Profile	11604.7	11-6-16
Special Review Circumstances	11604.8	11-6-21
Review Schedule Instructions	11604.9	11-6-24
Alternate System	11606	11-6-31
CPAS Plan	11607	11-6-32
General Requirements for Mandatory System Sample Selection	11608	11-6-32
Requirements for Sampling Plan Documentation	11608.1	11-6-38
Selection of Systematic and Simple Random Samples	11608.2	11-6-40
Procedures for Correcting the Monthly Sample for Excessive Oversampling and Undersampling	11608.3	11-6-43
Documentation Source Sheet	11609	11-6-47
Contents of the State CPAS File	11610	11-6-49
CPAS Corrective Action	11611	11-6-49
Appendix A		11-6-51
Appendix B		11-6-52

11600. BACKGROUND

Claims processing (CP) procedures begin when a provider's claim is received by the State Medicaid agency or its fiscal agent. Decisions are made as to whether or not payment will be authorized and, if so, the dollar amount of the payment. In order to make these decisions, the claim is processed in accordance with established State CP procedures and requirements. Although different from State to State, some basic procedures are common to all States.

The claim is examined to insure that:

1. It contains all the required information;

2. the information is internally consistent;

3. the recipient who received the service and the provider who submitted the claim were certified as eligible to participate in the program on the date(s) of service;

4. the service provided is covered under the program;

5. the service does not exceed frequency limitations;

6. any required prior authorizations or certifications were obtained.

If the claim conforms to these requirements, a decision is made as to the dollar amount to be paid. This amount is determined by appropriate fee schedules and fiscal policies.

The Claims Processing Assessment System (CPAS) is a State administered Medicaid Quality Control program which serves as a management tool for examining and evaluating the accuracy of claims processing and payments. Federal monitoring of State CPAS activities is accomplished through management reviews in either the System Performance Review (SPR) for certified MMIS States, the State assessment for non-MMIS States, or other Federal review. These reviews are used as the mechanism to determine which CPAS; (i.e., alternate or mandatory/superior) a State must operate subsequent to the review period.

11601. OVERVIEW OF CPAS

A. General.—All States are required to operate claims processing assessment systems that have the capability to perform the following functions:

1. Identify deficiencies in the claims processing operations;

2. measure the cost of deficiencies;

3. provide data to determine appropriate corrective action;

4. provide an overall assessment of the State's claims processing or that of its fiscal agent;

5. provide for a claim-by-claim review where justifiable by data; and

6. produce an audit trail that can be reviewed by HCFA or an outside auditor.

The above functions have been shown by demonstrations to be essential to an efficient CPAS plan. States with demonstrated superior performance may establish alternate claims processing assessment programs, subject to HCFA approval based on effectiveness, efficiency and economy.

B. Alternate System.—States whose claims processing systems are not affected by C below are allowed to operate an alternate claims processing assessment system using the methods of their choice subject to Federal criteria and approval. The alternate system could be an in-house independent audit, or an alternate quality control system. Any such system is subject to Federal approval prior to implementation. The required reporting for these States is minimal. States are not required to submit detailed samples. However, these States will be required to provide a report of the results of such assessments. (See §11606.)

C. Mandatory System.—A mandatory system, or a system that is judged superior, would be required of those States that:

1. Exceed a claims processing performance threshold. The threshold has been established as a payment error rate exceeding 1 percent and where misspent Federal funds annually exceed $1 million;

2. Make significant system changes (MMIS States only). A significant system change is defined as the replacement by an MMIS State of an approved claims processing subsystem, which must meet the conditions for initial approval of the MMIS; or,

3. Change system operators or fiscal agents and HCFA review determines that the performance of the CPAS in use does not adequately monitor the quality of the claims processing system during the transition.

The scope of the review process, documentation, development, and reporting requirements for the mandatory system are more comprehensive than for an alternate system. (See §11604.)

D. Superior System.—A State required to operate the mandatory CPAS must use this system or a system determined by HCFA to be superior. A superior system provides better data, more data, or comparable data at greater efficiency or economy. States could, for example, use additional strata, review denied claims, conduct special studies in problem areas, or increase automation.

E. Definitions.—The following definitions are for use within the context of the CPAS.

Certified Provider Listing.—An official State registry of providers and facilities authorized to receive reimbursement for services provided to State Medicaid recipients.

CFR.—Code of Federal Regulations.

Correct Payment Authorization.—The lesser of either the amount billed by a provider for a covered service or the amount specified for that service in the appropriate payment fee schedule (fee schedules, reasonable charge profiles, etc.).

Dollar Error.—An error that resulted in an erroneous payment authorization; i.e., an overpayment, underpayment, or total dollar error.

Medicare Crossover Payment.—Payment authorization by the State Medicaid agency for the Medicare deductible and coinsurance amounts.

Overpayment.—A dollar error in which the payment authorization amount is in excess of the correct payment authorization.

Payment Authorization.—The amount adjudicated for payment by the CP operational unit regardless of the amount of the check subsequently issued to the provider.

Payment Fee Schedule.—A listing of the maximum payment rates for specified services covered under the State's Medicaid program.

Permissible State Practice.—Written procedures, provider guides, office instructions, and policy manuals and issuances that are consistent with the State plan or with approvable State plan amendments which have been submitted to but not yet acted upon by the HCFA RO.

Prior Authorization.—Prior approval by the State agency to reimburse a provider for a specific service, if rendered.

Procedural Error.—An error that occurred during claims processing which may or may not result in a dollar error.

Recipient Paid Claim History File.—A listing, over a period of time, of medical services received by a recipient for which Medicaid reimbursement was provided.

The listing should provide the information necessary to conduct the QC review; e.g., the service rendered, units of service, date of service, provider of the service, date and amount of payment authorization, third party payment data.

Sample Unit.—A line item(s) representing the lowest level of payment adjudication for claims authorized for payment or adjustment. The most detailed claim breakdown for which a payment/adjustment determination is made and authorized. For purposes of the CPAS Manual, a sample unit is referred to as a "claim" in narrative discussions.

Total Dollar Error.—An error in which the full amount or part of the claim should have been disallowed; i.e., no portion of the payment/adjustment should have been authorized.

Underpayment.—A dollar error in which the payment authorization is below the correct payment authorization amount.

11604. MANDATORY SYSTEM

The mandatory system sample universe consists of all claims authorized for payment or adjustment by the State agency or its fiscal intermediary. Claims are subject to sample selection for the month in which payment is authorized rather than in the month in which the service was provided or in the month in which payment was actually made to the provider. Adjustments that increase or decrease previous payment authorizations are also subject to sample selection and review. However, claims for which no payment was authorized; i.e., denied claims, are not subject to sample selection.

The mandatory system provides data on the incidence of claims processing errors and the resulting cost of the errors in program dollars. Once a claim is selected, it is reviewed to determine (1) if it was processed in accordance with the State's CP procedures and (2) if the payment/adjustment amount authorized is correct. A CPAS Review Schedule is completed for each claim selected for review and is used to record information regarding the types and sources of errors found. The CPAS Review Schedule demonstrates a cause and effect relationship between occurrence errors and resulting dollar errors in the payment/adjustment authorization.

The mandatory system review is conducted in two major phases and produces two types of findings. In the first phase, the claim is reviewed to determine if it was processed correctly; that is, was all the necessary documentation present, were all the required procedures followed, were coding or data entry errors made, etc.? If processing errors were made, a procedural error is recorded on the CPAS Review Schedule. Procedural

errors are described by nature codes and may or may not result in an incorrect payment/adjustment authorization. (The CP operational unit may make errors in processing the claim but the payment authorization may still be correct.)

In the second phase the reviewer must develop any procedural errors found to determine whether they caused the payment authorization to be incorrect. Development means that the CP reviewer must obtain missing documentation, rework payment computations, or perform other activities necessary to determine if the payment authorization was correct. If incorrect, a dollar error is cited on the CPAS Review Schedule. Dollar errors are described in terms of the nature of the error, type of the error (underpayment, overpayment, etc.), and amount of the error. A dollar error finding is recorded on the CPAS Review Schedule with the procedural error which was most responsible for the dollar error. As a result, statistical data is generated which describes the relationship between procedural and dollar errors in States' CP systems.

The mandatory system review is conducted in consecutive 6-month cycles. Each sample period represents one-half of the Federal fiscal year (from October 1 through March 31 and from April 1 through September 30). Based upon the State agency's completed CPAS reviews, HCFA-CO generates statistical reports and tables for each 6-month review period.

11604.1 Scope.—Claim payment authorizations and adjustments subject to sample selection are grouped by provider type. The claims selected for payments include the following groups:

- o Inpatient hospital services (other than services for tuberculosis or mental diseases);
- o long-term care services;
- o other individual practitioners and clinics; and
- o separately billed prescribed drugs.

The mandatory system review is concerned with the most detailed claim breakdown for which a payment amount was determined and authorized for payment or adjustment; i.e., the lowest level of payment adjudication by the CP operational unit. In many instances the claim under review (sample unit) will be a single service (office visit, drug, etc.) listed as a separate line item on the provider's invoice. (Other line items appearing on the same invoice not in the sample unit are subject to separate sample selection and review.) In other instances the sample unit may be several services listed separately on the provider's

invoice but grouped together for payment determination purposes, or an inclusive rate payment made for an individual beneficiary (such as some hospital services, nursing home rates, etc.).

For CPAS purposes, claims processing is considered complete when an authorization for payment has been made. The claim is reviewed for correctness based on the amount authorized. Adjustments (increases and decreases) made subsequent to the payment authorization are considered separate CP actions and are subject to separate sample selection and review. Adjustments may be in the form of a supplemental payment authorization, a debit or credit to the provider's account, or a new payment authorization after a credit to the provider's account for the amount of the original claim.

The review is not limited to the provider invoice information but includes examination of supporting documentation, recipient paid claim history files, payment fee schedules, and other source documents required to reach a definitive review finding. The review is conducted in accordance with State plans, State practice (provided there is no conflict with the State plan), and the review instructions contained in this manual.

A. Permissible State Practice and the State Plan.—The review is conducted in accordance with permissible State practice; i.e., written provider guidelines, office instructions, and policy manuals and issuances that are consistent with the State plan or with approvable plan amendments which have been submitted to but not yet acted upon by HCFA.

In all instances where State practice conflicts with the State plan (or approvable amendments) State practice is not permissible and the review is conducted in accordance with the provisions of the State plan. Although the State plan preprint is a simplified document, it is designed to be consistent with Federal regulations. Where the State plan does not specifically address an issue and State practice conflicts with Federal regulations, the review is conducted against the CFR. If, however, the approved State plan specifically addresses an issue but is in conflict with Federal regulations, the review is conducted in accordance with the approved State plan.

State plan amendments submitted to HCFA for approval but not yet acted upon are considered in effect for review purposes if the amendments are approvable. Plan amendments are approvable so long as they do not conflict with the CFR. Plan amendments which conflict with Federal regulations are not approvable and cannot be honored for review purposes. The effective date of an approvable amendment may be prospective or retroactive, but may not be retroactive beyond the beginning of the calendar quarter in which the amendment was submitted. If the effective date of the amendment is not specified, the date it is submitted to HCFA is the effective date for review purposes. Once submitted, an approvable plan amendment remains in effect unless it is formally disapproved by HCFA.

B. Parameters of the Review.—Although payments and adjustments are subject to selection in the month of authorization, the review is conducted in accordance with policies, procedures, fee schedules, etc., in effect on the date(s) the service was provided or the date of payment authorization, as specified by permissible State practice. In instances where the service was provided over a period of days, particularly from one month to the next, it may be necessary to apply separate policies or fee schedules to the review when the dates of service span the effective date of a policy or fee schedule change. For example, one fee schedule may have been in effect for some of the services performed, but a different fee schedule became effective for the remaining services provided.

11604.2 Claims Not to be Reviewed.—Certain types of claims are not to be included in the mandatory CPAS sample universe. These will normally be eliminated in the sample selection process. Claims not to be included in the sample universe and considered listed in error if selected are:

1. Claims in which the payment authorization date is not within the sample month;

2. claims for which no Federal matching is claimed; i.e., are paid with State funds only;

3. claims that are an end-of-year institutional cost settlement;

4. claims that are 100 percent federally funded; and

5. claims listed under the incorrect provider type. (Claims included in the sample universe are stratified by provider type prior to sample selection options; i.e., hospitals, long-term care, individual practitioners and clinics, and prescription drugs.)

Due to the nature of the CP review and its documentation requirements, there are few valid reasons for not completing a correctly sampled case. For example, the absence of documentation is not a valid reason for an incomplete review. Reviews may be incomplete, however, when the State corrects for excessive oversampling in accordance with §11608.3.

11604.3. Review Completion and Reporting Requirements.—

A. Review Completions.— Submit to the HCFA RO, on a weekly basis, a copy of the Review Schedule for each review completed during the week. As a guideline, complete a minimum of 90 percent of the monthly sample selection within 60 days after the close of

the sample month. All CP reviews must be completed and submitted to the HCFA-RO by the end of the ninth month of the review cycle; e.g., June 30 for the October-March period and December 31 for the April-September period.

As a rule, State review findings are considered final when submitted to the HCFA-RO and may not be changed.

B. Reports.—States are required to submit monthly reports to the HCFA RO which contain sample selection data and disposition lists. Monthly reports are due to the HCFA RO within 5 working days after the end of the review month.

Using copies of the review schedules and the monthly reports, HCFA CO will generate status reports to monitor State completions and the 6-month statistical reports and tables.

States must also report claims and dollar universe figures by strata within 30 days after the end of the sampling period.

11604.4 Review Procedures.—The following sections outline the review steps, data needs and source documents, development, and error determination instructions for the claims reviews.

A. Steps in the Review.—As previously noted, the claim is reviewed in accordance with the State plan. In order to adequately meet the review requirements, the reviewer must have a thorough understanding of permissible State practice, the State plan, and a familiarity with the CFR. The reviewer must use this knowledge to:

1. Determine the policies and fee schedules in effect for the date(s) of service and/or the payment authorization date, whichever is applicable under permissible State practice;

2. determine the documentation required to process the claim;

3. determine if the unit followed the correct processing procedures; and

4. develop the review to determine if a correct payment authorization was made.

B. Below is a list of some of the specific steps which must be considered for each claim selected for review.

1. Payment for Services.—Check the invoice or paid claims file to determine:

a. If the claim was properly selected for review; i.e., was not listed in error;

b. the line item(s) under review;

c. the review parameters established by the date(s) of service and/or payment authorization date; and

d. the amount of payment/adjustment authorization.

2. Provider Eligibility.—Compare the date(s) of service with the provider eligibility file to determine if the provider was, in fact, certified to participate in the program for the day(s) the service was rendered.

3. Recipient Eligibility.—Determine who the recipient was and establish that the recipient appeared on the Medicaid eligibility file for the month(s) covered by the date(s) of service.

4. Covered Services.—Compare the type of service provided with the services covered under permissible State practice to determine if the claim under review was for a covered service.

5. Required Invoice Information.—Determine if all required information was provided on the invoice. If not, develop missing information required to complete the review.

6. Appropriate Billing Procedures.—Determine if the provider followed the correct billing procedures when submitting the claim. Areas of consideration include, but are not limited to, compatability of diagnosis and procedures, and inclusion of required support documentation (i.e., operative reports).

7. Prior Authorization.—Providers must obtain approval from the State prior to delivery of certain services if reimbursement is to be provided. Establish if prior authorization was required, if prior authorization was obtained and documented, and that the service provided was not in excess of any limitation set by prior authorization requirements.

Where the State provides for a waiver of prior authorization under certain circumstances, such as an emergency, verify that the waiver and subsequent authorization were granted or can be granted in accordance with permissible State practice. If a payment was appproved without prior authorization, or waiver if provided for, a procedural error is cited. If prior authorization was not obtained and a waiver of prior authorization can not be granted, both a procedural and a dollar error must be cited.

8. Level of Care Certification.—Where the State plan, or if not specified, permissible State practice requires evidence of certification prior to payment authorization, verify that the required certification was obtained. If not obtained prior to payment authorization, a procedural error is cited. Then determine if certification existed at the time of payment authorization. If certification at the time of payment authorization cannot be documented, a dollar error must be cited.

9. Duplication of Payment Frequency Restrictions.—Ascertain that a separate payment was not authorized for the service under review; i.e., the payment authorization under review does not duplicate a previous authorization. (Where a duplicate billing on a single invoice results in a duplicate authorization, the claim(s) appearing after the first claim on the invoice is considered a duplicate.) To determine if the sample unit is a duplicate payment authorization, compare the claim against a paid claims history which covers the period of time in which a claim can be submitted for payment as defined by permissible State practice.

In addition, determine whether a service was provided more frequently than allowed under permissible State practice. To accomplish this consider both the limitation on the number of times a service may be performed and any differences in the rate of payment for initial and subsequent services. Compare the claim against the claims history for the entire period of time the service under review is subject to frequency limitations under permissible State practice.

10. Authorized Payment Amount.—Verify the correctness of the claim amount authorized by consulting fee schedules, reasonable charge profiles, or by recalculating relative value based payments.

11604.5 Data Needs and Source Documents.—The reviewer is responsible for utilizing all documents and references necessary to determine if the claim was processed in accordance with required procedures and if the payment authorization was correct.

Source documents vary from State to State. For example, the original invoice, a photocopy of the original, or microfilm/microfiche may be utilized. Where the original invoice was submitted via electronic data transfer, a printout produced from the original transmission and containing all data relevant to the review is acceptable. Invoices are often annotated by State personnel during the various processing steps. The reviewer must ascertain if changes made to an invoice after submission by the provider could affect the error determination. Where the invoice has been altered during processing or where microfilming is not done prior to processing, it may be necessary to obtain the original hard copy invoice or verify key information via the provider's records.

The following are examples of data needs necessary for review. Also listed are some of the source documents from which to extract the information.

DATA NEEDS	SOURCE DOCUMENTS
1. Sample selection data; provider stratum and sample month.	Listing of sample units selected for review and the State's sampling plan.
2. Invoices containing the line items sampled.	Microfilm/microfiche files; original or copy of invoice; electronic data transfer printout.
3. Payment Data.	Recipient paid claim history file; authorization for payment.
4. Provider Eligibility Status for Month(s) of Service.	Computer generated or other listing of eligible providers for month(s) of service.
5. Recipient Eligibility Status for Month(s) of Service.	Computer generated or other listing of eligible recipients for month(s) of service.
6. Service Frequency Limitations.	Permissible State practice; recipient paid claim history file; fee schedules; screens and edits used in claims processing.

DATA NEEDS	SOURCE DOCUMENTS
7. Allowable Payments for Services During the Service Date(s) or Payment Authorization Date.	Specified fee schedules by area; listing of payment screens or edits used in claims processing; relative value scales (RVSs) for services and conversion factors (RVS multiplied by conversion factor yields fee); listing of "usual and customary" charges by provider group; hospital and nursing home reimbursement guides or manuals.
8. Services Covered by the State Medicaid Program.	Permissible State practice; drug guides; fee schedules; provider reimbursement manuals.
9. Prior Authorization Requirements.	Permissible State practice; fee schedules.
10. Requirements for Physician Certification.	Permissible State practice.

11604.6 Development and Error Determination.--

A. Development refers to the process of determining whether a procedural error resulted in a dollar error. All procedural errors are subject to development to the point necessary to determine the effect of the error on the payment authorization. Although all procedural errors are cited on the CPAS Review Schedule, development to determine dollar errors ceases at the point a total dollar error is found; i.e., the full amount of the claim should have been disallowed. Therefore, develop first those procedural errors found which could result in a total dollar error.

When development requires that the reviewer obtain documentation that was required, but missing when the claim was processed, the quality control unit will first contact the State operational unit to obtain the missing documentation. Examples of required documentation are:

1. The invoice containing the line item under review;

2. prior authorization forms;

3. physician certification when the operational unit is required to verify certification prior to payment authorization.

If the State CPAS unit is able to supply existing documentation, and demonstrate that it was available when the claim was processed, no error will be cited. If the State CPAS unit must obtain new documentation; e.g., contact the provider, a procedural error is cited because the claim was processed without the required documentation. The correctness of the payment authorization is then reviewed based upon the new documentation.

If the operational unit fails to secure the required documentation, the State CPAS unit should obtain the missing documentation if possible. However, the ultimate responsibility and burden of proof rests with the State operational unit to demonstrate that the payment authorization was appropriate. If the required documentation cannot be obtained or is unacceptable, a dollar error must be cited. For example, if evidence of prior authorization cannot be obtained, it must be assumed that prior authorization was not granted.

Although the operational unit may obtain the necessary documentation, the CPAS unit must determine if the documentation is acceptable. Documentation which is acceptable in place of the original is:

1. A copy of the documentation from the provider's records;

2. a signed and dated statement from the provider containing the required data; or

3. a quality control reviewer's narrative of a telephone contact with the provider supplying the necessary documentation.

B. Error Determination.—The review measures the correctness of payment authorizations/adjustments by identifying claims processing errors and resulting dollar errors. Procedural errors occur during the processing of a claim and may or may not cause a dollar error. Dollar errors result in the payment authorization being in error, either a total dollar error, overpayment, or underpayment. A major objective of the CP review is to identify procedural errors and their effect on the correctness of the payment authorization. As a result, the nature of error codes for procedural errors are different than the nature of error codes for dollar errors.

In making an error determination, first record all procedural errors found using the error code which best describes the nature of the procedural error. Then determine if the procedural error(s) resulted in a dollar error(s). If so, record an error code which best describes the nature of the dollar error.

Although the review is designed to establish a cause and effect relationship between procedural and dollar errors, the relationship is not always one-to-one. For example, the reviewer may determine that three procedural errors occurred during the processing of the claim, but that only one dollar error resulted. All three procedural errors are coded on the review schedule, but the resulting dollar error is only recorded once. In such instances, determine which procedural error most directly caused the dollar error.

11604.7 Error Category Profile

A. Nature Codes.—Nature codes are divided into seven categories under two major headings: procedural and dollar errors. Each category is divided into numerical subcategories describing the specific nature of the error. The specific nature of an error to be coded on the review schedule is the number of the error category and the number of the error subcategory which best describes the specific error. For example, a documentation procedural error cited because of no evidence of a claim would have the nature code 01.

B. Procedural Error Heading.—Procedural errors are divided into three categories: (1) Documentation, (2) Coding/Data Entry, and (3) Other Errors. Errors found in these three categories are recorded under the Procedural heading of the CPAS Review Schedule only and cannot appear under the Dollar heading.

Permissible State practice determines which subcategories of the Error Category Profile are applicable to the claim under review. When making the determination note that non-line item requirements associated with the adequacy of the invoice information; e.g., appropriate I.D. numbers, signature, are within the scope of the review and are associated with the appropriate procedural error category in the profile. Each procedural error found is to be recorded on the review schedule and is subject to development to determine if a dollar error also occurred. Since further development stops when a total dollar error is found, development should be completed first on those procedural errors most likely to result in a total dollar error.

1. Documentation.—Cite when a payment/adjustment is authorized without the information or verification required by permissible State practice. Each documentation error found is to be recorded and subject to development.

CODE	DESCRIPTION
01.	No evidence of claim submittal (no invoice).
02.	Physician/provider signature omitted or questionable.
03.	Recipient signature omitted or questionable.
04.	Required recipient identification missing or questionable.
05.	Required physician/provider identification missing or questionable.
06.	Referring physician identification missing or unclear.
07.	Prior authorization missing or unclear.
08.	Level of care certification missing or unclear.
09.	Date(s) of service missing or questionable.
10.	Diagnosis, procedure codes, and/or narrative description missing or questionable.
11.	Number of services missing or unclear.
12.	Drug type not specified or questionable.
14.	Dollar amount of claim missing, unclear, or questionable.
15.	Unauthorized force coding to bypass reasonable charge, fee schedule, or other edits.
19.	Other required information/documentation missing, incomplete, or unclear. Use the reverse side of the CP Review Schedule to explain this error more fully.

2. Coding/Data Entry.—Cite when an error is made by the State agency in coding invoice or payment data, or in entering computer data. Each coding/data entry error found is to be recorded and is subject to development.

CODE	DESCRIPTION
20.	State entered incorrect code to identify noncoded recipient invoice data; e.g., recipient identification, sex type,
21.	State entered incorrect code to identify noncoded provider invoice data; e.g., provider code,
22.	State entered incorrect code to describe noncoded service data; e.g., procedure codes, drug type, billing codes,
23.	State made keypunch error when transcribing coded data.
29.	Other coding/data entry error not identified above. Describe on reverse side of review schedule.

3. Other.—Each of the following procedural errors found are to be recorded and are subject to development.

CODE	DESCRIPTION
30.	Nonpermissible State practice - Written claims processing policy or procedure not in conformance with the approved State plan. (See §11604.1.)
39.	Other procedural errors not cited above. This code is also used when a dollar error cannot be identified with a specific procedural error described above. Explain error fully on reverse side of the review schedule.

C. Dollar Error Heading.—Dollar errors are divided into four categories, (1) Eligibility, (2) Coverage, (3) Payment, and (4) Reasonable Charge. Errors found in these four categories are recorded under the Dollar heading of the CP Review Schedule. Since the review ends with the identification of a total dollar error, first develop those procedural errors which may result in a determination that the full amount of the payment authorization should have been disallowed. To assist the reviewer, probable total dollar errors are indicated on the Error Category Profile by an asterisk. Permissible State plans determine which subcategories of the profile are applicable to the claim under review.

1. Eligibility.—Cited when the provider or the recipient was not certified as eligible to participate in the Medicaid program during part or all of the service date(s).

	CODE	DESCRIPTION
*	40.	The provider was not certified as eligible.
*	41.	The recipient was not certified as eligible.

2. Coverage.—Cite when permissible State practice prohibits reimbursement for the service(s) under review.

	CODE	DESCRIPTION
*	50.	Service not covered under the permissible State practice.
*	51.	Service exceeded the frequency limitation. This code is used when the frequency limitation has been exceeded by the authorization for the payment under review.
*	52.	No required physician certification. Level of care certification requirements not met on service date(s).
*	53.	No required prior authorization. The State agency has not met required prior authorization requirements.
*	54.	Claim processed although the filing deadline had expired.

*	55.	Additional EPSDT screening within prohibited time period.
*	56.	EPSDT screening service for a recipient age 21 or over.
*	57.	Inpatient charge includes both day of admission and day of discharge.
*	58.	Setup charges allowed although surgery was cancelled.
*	69.	Other coverage errors not specified above. Explain on reverse side of review schedule.

3. Payment.—Cite when a computation or payment determination error resulted in an incorrect payment authorization.

	CODE	DESCRIPTION
*	70.	Unable to verify that service was rendered.
*	71.	Duplicate payment authorized.
*	72.	Incorrect provider paid.
	73.	Copayment amount incorrectly applied.
	74.	Mathematical error resulted in incorrect payment authorization amount.
	79.	Other payment errors not specified above. Explain on reverse side of review schedule.

4. Reasonable Charge.—Cite when errors were made in applying reasonable charge rates, fee schedules, etc.

CODE	DESCRIPTION
80.	Incorrect reimbursement rate (fee schedule) applied.
81.	New patient code used although claims history shows previous patient charge by the same provider.
82.	Billed services improperly combined into service coverage package.
83.	Payment authorized for more than one dispensing fee when a prescription was split by the pharmacist.
84.	Payment authorized for drugs where the quantity prescribed is greater than the maximum quantity allowed by permissible State practice.
85.	Payment authorized for a maintenance drug where the quantity prescribed is less than the minimum allowed by permissible State practice.
89.	Other reasonable charge errors not specified above. Explain on reverse side of review schedule.

D. Type Codes.—In addition to being described by nature codes, errors are also described by type. There are five error type categories:

1. No Dollar Error.—Procedural errors which, when developed, did not result in a dollar error. For example, the claim may have been processed without required documentation, but when the documentation was obtained it was determined that the payment authorization was in the correct amount.

2. Total Dollar Error.—Dollar errors in which the full amount of the payment authorization under review should have been disallowed; i.e., an overpayment in the full amount of the payment authorization. Development is ended after a total dollar error is identified.

3. Overpayment Error.—Dollar errors in which the payment authorization was in excess of the correct payment authorization amount.

EXAMPLE 1:

Dollar Amount Billed	$15.00
Appropriate Reimbursement Rate	$10.00
Dollar Amount Authorized	$15.00

The overpayment error is the difference between the reimbursement rate and the amount authorized. The error amount is $5.00.

EXAMPLE 2:

Dollar Amount Billed	$15.00
Appropriate Reimbursement Rate	$25.00
Dollar Amount Authorized	$25.00

In example 2 the overpayment is the difference between the dollar amount billed and the dollar amount authorized. Here the error amount is $10.00.

4. Underpayment Error.—Dollar errors in which the payment authorized is less than the correct payment authorization amount.

EXAMPLE 1:

Dollar Amount Billed	$15.00
Appropriate Reimbursement Rate	$10.00
Dollar Amount Authorized	$ 5.00

In example 1 the underpayment error is the difference between the reimbursement rate and the dollar amount authorized. In this example it is $5.00.

EXAMPLE 2:

Dollar Amount Billed	$20.00
Appropriate Reimbursement Rate	$25.00
Dollar Amount Authorized	$10.00

In example 2 the underpayment error is the difference between the dollar amount billed and the dollar amount authorized. It is $10.00.

5. Nondeveloped Procedural Error.—Procedural errors which were: a) not developed to determine if they resulted in a dollar error, or b) resulted in a dollar error but the dollar error is assigned to another procedural error.

Code 5 is used to designate procedural errors which were not developed because the review was completed after identifying a Total Dollar Error or when several procedural errors resulted in the same dollar error. (Since the dollar error is coded with the procedural error most responsible, other procedural errors are coded as type 5 - Nondeveloped.)

11604.8 Special Review Circumstances.—

A. Third Party Liability.—Since TPL dollar errors are not within the scope of the CP review, no development of procedural errors is necessary.

B. Adjustments.—

1. Amount.—Only the net amount of the adjustment is under review. In most instances the adjustment amount is the full amount of the supplemental authorization, credit or debit. In other instances, if the initial payment was cancelled and a new payment authorized to the same provider, the adjustment is the difference between the original amount authorized and the new amount authorized; i.e., the net amount. For example, the original authorization in the amount of $20 was cancelled and a new payment authorized in the amount of $15. Although the $15 authorization must be reviewed for correctness, the amount of the adjustment reported on the CPAS Review Schedule is a $5 decrease.

In instances where the original payment is cancelled and a new payment authorized to a different provider, the amount of the adjustment is the amount of the cancellation. The new payment authorization to a different provider is not considered part of the adjustment and is to be subject to separate sample selection.

2. Correctness.—In order to determine the correctness of adjustments, they must be reviewed in relation to the correctness of the original payment authorization and any prior adjustments. To be correct, the adjustment must be based upon an accurate assumption. For example, an adjustment may be authorized to increase an original payment. This assumes that the original authorization was less than can be allowed under permissible State practice. If, however, a review of the original authorization revealed it to be an overpayment, the assumption, and consequently, the adjustment are in error.

The original authorization must be examined as if it were the claim selected. That is, procedural errors are identified and developed in order to determine the correctness of the original payment authorization. The adjustment is then reviewed to determine if any original errors found, both procedural and dollar, were corrected or otherwise compensated for by the adjustment. If not, the errors carry forward to the adjustment and are coded on the CPAS Review Schedule. If, for example, a claim was originally processed without required documentation and the adjustment was processed without obtaining the documentation, a documentation procedural error is charged to the adjustment (unless, of course, the adjustment was to cancel the original payment authorization due to a lack of required documentation). Likewise, any dollar errors occurring in the original payment authorization, if not corrected in the adjustment process, may contribute to an adjustment dollar error.

The following outlines the types of adjustment dollar error findings which may result depending upon the correctness of the original payment authorization.

1. Original Authorization Correct and Paid in the Amount Specified in the Appropriate Fee Schedule.—

a. Adjustment to Increase.—Net amount of increase reported as total dollar error.

b. Adjustment to Decrease.—Net amount of decrease reported as underpayment.

2. Original Authorization Correct but Provider Billed Less Than Specified in Appropriate Fee Schedule.—

a. Adjustment to Increase.—Can be correct only if provider requests adjustment.

(1) Net amount of increase correct if in amount of adjustment request or amount specified in the appropriate fee schedule, whichever is the lesser amount.

(2) Underpayment coded if net amount of increase is less than the correct adjustment amount as specified in (1) above.

(3) Overpayment coded if net amount of increase is more than the correct adjustment amount as specified in (1) above.

b. Adjustment to Decrease.—Net amount of adjustment reported as underpayment.

3. Original Authorization a Total Dollar Error.—

a. Adjustment to Increase.—Net amount of increase reported as total dollar error.

b. Adjustment to Decrease.—

(1) Any amount of decrease correct up to the amount of original payment authorization.

(2) Any amount of decrease beyond original payment authorization reported as an underpayment.

4. Original Authorization an Overpayment.—

a. Adjustment to Increase.—Net amount of increase reported as a total dollar error.

b. Adjustment to Decrease.—

(1) Any amount of decrease correct up to the amount of the original overpayment.

(2) Any amount of decrease beyond original overpayment amount reported as underpayment.

5. Original Authorization an Underpayment.—

a. Adjustment to Increase.—

(1) Any amount of increase correct up to the amount of original underpayment.

(2) Any amount of increase beyond original underpayment reported as overpayment.

b. Adjustment to Decrease.—

(1) Net amount of decrease reported as an underpayment.

11604.9 Review Schedule Instructions.—

Complete a HCFA 331 CPAS Review Schedule for each sample unit selected for review.

SECTION I - CLAIM INFORMATION

Complete this section for each sample unit selected for review.

1-4. Optional State Use.—Enter claim or review information if desired. For example, recipient identification, reviewer identification, date assigned, date completed,

5. Local Code.—Enter the code, if applicable, that identifies the county or local agency that certified the recipient as eligible for Medicaid, or the fiscal intermediary that authorized the payment.

6. Sample Unit Number.—Enter the number (invoice - line item number) which identifies the sample unit selected for review.

7. State Code.—Enter the two-digit code for the State in which the review was selected. (See appendix A for State codes.)

8. Sample Month/Year.—Enter the month and year that corresponds to the specified sample month from which the sample unit was selected. States may specify a sample month other than a calendar month if their payment procedures operate on a fixed fiscal month basis. The sample month is specified in the approved State sampling plan.

9. Review Number.—Enter the number, alpha and/or numeric, assigned to the review. Enter zeros in any unused data positions.

10. Date(s) of Service.—Enter the date(s) of service covered by the payment authorization under review.

FROM: Enter the first day of service (month/day/year) covered by the payment authorization under review.

TO : Enter the last day of service (month/day/year) covered by the payment authorization under review.

Where the service was provided during a single day, the "from" and "to" dates will be the same.

11. Date Payment Authorized.—Enter the date (month/day/year) the claim was authorized for payment.

If the date the claim was authorized for payment is not within the sample month, calendar or fiscal, the claim is listed in error.

12. Service Type.—Enter the code that identifies the type of service under review. (See appendix A for type of service codes.)

Service codes are divided into series 100-500 by provider type. Series 200, 300, and 500 are subdivided by types of service.

13. Claim Type.—Enter the number that corresponds to the type of claim selected for review. For adjustments it will be necessary to conduct the review before the appropriate adjustment code can be determined. (See §11604.8-Adjustments.)

(1) Original.—Enter the number one if the claim selected for review is the first adjudicated claim payment determination; i.e., the initial payment determination for an invoice prior to any adjustments.

(2) Adjustment to Increase/Original Authorization Correct.—Enter the number two if the claim selected for review is an adjustment to increase the amount of a previous correct payment authorization.

(3) Adjustment to Increase/Original Authorization Incorrect.—Enter the number three if the claim selected for review is an adjustment to increase the amount of a previous incorrect (over- or underpayment) payment authorization.

(4) Adjustment to Decrease/Original Authorization Correct.—Enter the number four if the claim selected for review is an adjustment to decrease the amount of a previous correct payment authorization.

(5) Adjustment to Decrease/Original Authorization Incorrect.—Enter the number five if the claim selected for review is an adjustment to decrease the amount of a previous incorrect (over- or underpayment) payment authorization.

14. Amount Authorized.—Enter the amount authorized for payment or adjustment for the sample unit selected for review without regard to any subsequent adjustments to the payment amount. For adjustments, see section for explanation of amount authorized.

SECTION II - REVIEW DISPOSITION

Complete this section for each sample unit selected for review. Enter the number that corresponds to the disposition of the review.

1. Review Completed.—Enter the number one if a review finding is reached; i.e., item 15, is coded.

2. Listed in Error.—Enter the number two if the claim selected for review is listed in error. Use the space provided to explain the reason the claim is listed in error. The claim is listed in error if:

a. The date of payment authorization, item 11, is not within the specified sample month from which the claim was selected, item 8; or

b. the claim selected for review was denied; i.e., not authorized for payment;

c. the sample unit selected was listed on the wrong provider type sample listing prior to sample selection;

d. the sample unit selected is not a federally matched Medicaid claim; i.e., is paid with State funds only;

e. the sample unit selected for review is an end-of-year institutional cost settlement; or

f. the sample unit selected was 100 percent federally funded.

Incomplete.—Enter the number three if the claim was not listed in error but the review was not completed. (See §11604.2 - Claims Not To Be Reviewed.)

SECTION III - REVIEW FINDINGS

Complete this section for each sample unit selected for review that was not listed in error.

15. Findings Status.—Enter the number that corresponds to the findings status of the sample unit selected for review.

a. Correct.—Enter the number one if no procedural or dollar errors were found during the review.

b. Procedural Error.—Enter the number two if only procedural errors were found during the review.

c. Procedural and Dollar Error.—Enter the number three if procedural errors resulting in dollar errors were found during the review.

16. Error Data.—Complete this item for each sample unit determined to contain a procedural or dollar error; i.e., number 2 or 3 was entered in item 15.

A. Procedural Errors - Nature. Enter the code from the Error Category Profile which best describes the nature of the procedural error found.

Record all procedural errors, working from the top to the bottom, identified during the review. If more than five procedural errors are identified, attach an additional review schedule in order to capture all procedural errors identified.

Develop each procedural error recorded to determine if it resulted in a dollar error.

Exceptions: TPL procedural errors are not developed. Secondly, if the development of a procedural error results in a Total Dollar Error (the full amount of the paid claim being overpaid), the review ends without the development of the remaining procedural errors. An overpayment or underpayment, however, does not end the review because subsequent errors may offset or compound the first error found.

B. Type.—Enter the number that corresponds to the type of the dollar error determination; i.e., no error, total dollar, overpayment, underpayment, TPL procedural, or nondeveloped procedural error.

1. No Dollar Error.—Enter the number one if the procedural error, when developed, did not result in a dollar error.

2. Total Dollar Error.—Enter the number two if the procedural error resulted in an overpayment in the full amount of the payment; i.e., the amount entered in item 14 should have been totally disallowed.

3. Overpayment.—Enter the number three if the procedural error resulted in an overpayment (the amount authorized was more than the correct authorization amount) but not in a total dollar error.

4. Underpayment.—Enter the number four if the procedural error resulted in an underpayment; i.e., the amount authorized was less than the correct authorization amount.

5. TPL Procedural Error.—Enter the number five if the procedural error was a TPL error (code 13 or 31).

6. Nondeveloped Procedural Error.—Enter the number six if the procedural error was not developed (because a total dollar error was found) or although resulting in a dollar error, the dollar error was assigned to another procedural error.

C. Dollar Errors--Nature.—If the procedural error results in a dollar error, enter the code from the Error Category Profile which best describes the nature of the dollar error. If the procedural error is not developed, if development does not result in a dollar error, or if the dollar error has been reported (associated) with another procedural error, leave item C, Dollar Errors--Nature, blank.

After development of a procedural error, enter the dollar error data directly across from the procedural error; i.e., in line with the procedural error nature code.

Example -

Procedural Errors		Dollar Errors	
A. Nature	B. Type	C. Nature	D. Amount
23	2	71	$ 000134 00

D. Amount.—If a 2, 3, or 4 is entered under item B, Type, enter the amount, in dollars and cents, of the error. If the number 1, 5, or 6 is entered in item B, item D is left blank.

The amount of a total dollar error is the full amount of the payment authorization under review. The amount of an overpayment or underpayment is the difference between the amount authorized and the correct payment authorization amount. The correct payment authorization amount is the amount specified in fee schedules or the amount billed, whichever is smaller.

17. Net Dollar Error Findings.—Complete this section if more than one dollar error was recorded in item 16-B.

A. Net Dollar Error Amount.—Enter the net dollar amount of all dollar errors combined. The net dollar error amount is determined by adding all overpayments together and subtracting all underpayments, and is the difference between the amount authorized and the correct payment authorization amount.

B. Type.—Enter the number which corresponds to the type of the net dollar error finding.

1. No Net Dollar Error.—Enter the number one if overpayments and underpayments cancelled each other to result in no dollars being authorized in error.

2. Total Dollar Error.—Enter the number two if the net amount of all dollar errors results in an overpayment in the full amount of the payment authorization (item 16).

3. Overpayment.—Enter the number three if the net amount of all dollar errors results in an overpayment but not in a total dollar error.

4. Underpayment.—Enter the number four if the net amount of all dollar errors results in an underpayment.

SECTION IV - OPTIONAL USE CODES

This section is provided for optional State use.

SECTION V - RE-REVIEW FINDINGS

Do not complete this section. It is for Federal regional office re-review purposes only.

CLAIMS PROCESSING ASSESSMENT SYSTEM REVIEW SCHEDULE

SECTION I — CLAIM INFORMATION

1. | 2. | 3. | 4. | 5. LOCAL CODE (1 2 3)

6. SAMPLE UNIT NUMBER | 7. ST. CODE (4 5) | 8. SAMPLE MO./YR. (6 7 8 9) | 9. REVIEW NUMBER (10 11 12 13 14 15)

10. DATE(S) OF SERVICE
FROM (16 17) (18 19) (20 21) TO (22 23) (24 25) (26 27)

11. DATE PAYMENT AUTHORIZED (28 29) (30 31) (32 33)

12. SERVICE TYPE (34 35 36)

13. CLAIM TYPE
1-ORIGINAL
2-3 ADJ. INCREASE
4-6 ADJ. DECREASE
(37)

14. AMOUNT AUTHORIZED (38 39 40 41 42 43) (44 45)

SECTION II — REVIEW DISPOSITION

1- REVIEW COMPLETED
2- LISTED IN ERROR
3- INCOMPLETE
EXPLAIN: _____ (46)

SECTION III — REVIEW FINDINGS

15. FINDINGS STATUS (47)
1- CORRECT
2- PROCEDURAL ERROR
3- PROCEDURAL & DOLLAR ERROR

16. ERROR DATA

PROCEDURAL ERRORS A. NATURE		B. TYPE	DOLLAR ERRORS C. NATURE	D. AMOUNT
(48 49)	_____	(50)	(51 52)	(53 54 55 56 57 58) (59 60)
(61 62)	_____	(63)	(64 65)	(66 67 68 69 70 71) (72 73)
(74 75)	_____	(76)	(77 78)	(79 80 81 82 83 84) (85 86)
(87 88)	_____	(89)	(90 91)	(92 93 94 95 96 97) (98 99)
(100 101)	_____	(102)	(103 104)	(105 106 107 108 109 110) (111 112)

17. NET ERROR FINDINGS
A. AMOUNT (113 114 115 116 117 118) (119 120)
B. TYPE (121)

SECTION IV — OPTIONAL USE CODES

(122 123 124 125 126 127) (128 129 130 131 132 133) (134 135 136 137 138 139)

SECTION V — RE-REVIEW FINDINGS (FOR FEDERAL USE ONLY)

18. REVIEW NUMBER (140 141 142 143 144 145)

19. SUB-SAMPLE CASE (146)
1- YES 2- NO

20. APPROVED ST. PLAN CONFLICTS WITH CFR (147)
1- YES 2- NO

21. CONCURRENCE (148)
1- YES 2- NO

22. RESOLUTION (149)
1- SUSTAINED 2- REVERSED

FORM HCFA-331 (6-81)

11-6-30 Rev. 6

11606. ALTERNATE SYSTEM

The purpose of the alternate system is to allow States not required to perform a mandatory system to determine the type of claims processing quality control system they feel will best serve their needs.

Alternate systems may take many forms. These systems may involve computerized reviews of the entire claims file, reviews which focus upon certain claims strata or aspects of the claims processing, and other subsystems, etc.

Alternate systems must be able to:

1. Identify deficiencies in the claims processing,
2. measure the cost of deficiencies,
3. provide data to determine appropriate corrective action,
4. provide an overall assessment of the State's claims or that of its fiscal agent,
5. provide for a claim-by-claim review where justifiable by data, and
6. produce an audit trail that can be reviewed by HCFA or an outside auditor.

Each State which qualifies to operate an alternate system must submit a plan to the HCFA regional office detailing how their system will operate and what data is to be generated from their system. No specific format is required for the submission of this plan. States must receive prior approval before implementing an alternate system.

Reporting Requirements.--States operating alternate systems must provide an annual report of the results of their CP assessment to the HCFA-RO no later than August 31. Detail the methodology employed in determining errors and include descriptions of errors. Deficiencies discovered in the CP system and actions taken to correct deficiencies must also be detailed.

Deficiencies in claims processing operations are:

1. Payment for incorrect, inconsistent, or incomplete claims;
2. errors which result in incorrect, inconsistent or incomplete data entries;
3. payment to a provider not eligible to participate in the program;
4. payment for a service furnished to an ineligible individual;
5. payment for services not authorized by regulation or policy;
6. payment above allowable charges or costs;
7. payment for which an individual was responsible; and
8. duplicate payment.

11607. CPAS PLAN

The CPAS plan is utilized by all States participating in the Medicaid program. The plan includes varying types of information depending upon the type of claims processing review system the State operates. Each plan will be subject to prior HCFA approval before implementation.

For States required to implement a mandatory system, the plan is a sampling plan detailing the type of statistical sampling methodology and types of claims that are sampled. States that elect to operate a superior system or States operating an alternate system are required to submit a plan which details the type of CPAS that they operate. At a minimum, each superior system must meet the criteria outlined in §11604. Each State operating an alternate system must meet the criteria outlined in §11606.

States are required to submit its CPAS plan to the HCFA-RO at least 60 days prior to the beginning of the fiscal year or prior to the implementation date if their CPAS is being changed. Extentions of up to 30 days may be approved by the HCFA-RO if the State cannot complete the plan timely. If the State obtains an extention, the HCFA-RO may require the State to make changes to its CPAS plan with 90 days after it is submitted, even if it is made after the CPAS implementation date.

11608. GENERAL REQUIREMENTS FOR MANDATORY SYSTEM SAMPLE SELECTION

The CP review involves a sample review of all Medicaid line items authorized for payment conducted over two 6-month cycles. Each sample period represents one-half of a fiscal year, from October 1 through March 31 and April 1 through September 30. The line item sample is comprised of monthly sample selections from each month's universe of authorized line items. Review of the selected line items is conducted according to the instructions outlined in §11606. Note that the CP sample is not stratified by eligibility category as is the eligibility sample.

A. Sample Unit.—The sample unit for the CP quality control (QC) sample is an individual line item on an invoice for which the State has authorized payment within the specified payment sample month. Payment authorization is the final act of approval for payment, subsequent to all editing and prior to, or coincident with, the actual associated check issuance. A line item is defined as the most detailed claim breakdown at which payment adjudication is determined. For example, for hospitals which bill on a per diem rate, the line item is the total for an individual's services even if dollar amounts are shown for each service. If the State allows ancillary charges to a per diem-based bill, each ancillary service is a separate line item and subject to sample selection. The only exception to the basic line item definition is where billing covers more than one

individual. In this instance, sampling must always be specific by individual. Line items which cover services over more than one month are subject to selection in the month they are authorized for payment. Adjustments are subject to sampling the month they are authorized for payment. Adjustments are sampled as units authorized for payment but are reviewed for their net amount. Line item adjustments made by cancelling a previous payment authorization (or debiting a provider's account) and then repaying in the adjusted total amount to the same provider are sampled as one net adjustment. Adjustments resulting in negative payment amounts are also included in the sampling frame.

Note that the above definition does not differentiate between hard copy, tape to tape, and other automated billing formats. All claims, once authorized for payment, are included in the appropriate sampling frame regardless of their original form.

B. Sample Sizes.—Minimum numbers of line items for which reviews must be completed have been established for each State. These requirements are the basis for determining the actual number of selected line items. The actual number of sample line items to be selected depends on the expected number of noncompleted reviews.

For States with exceptionally small universes of line items, HCFA will consider reducing the minimum sample size. This reduction will be limited to the effect of the finite population correction factor. States must request this reduction in their initial sampling plan submittal.

C. Populations To Be Sampled.—The line item universe is comprised of all Medicaid line items authorized for payment by the State agency during a month. The CP line item sample may be stratified based on different provider types. This stratification allows for an improved allocation of review effort based on the dollars at risk in that stratum. These line items are sampled from the following stratified sampling frames, but States may elect to not utilize all of these types in their system.

1. Billings for Inpatient Hospital Services.
2. Billings for Long-Term Care Services.
3. Billings From Other Individual Practitioners, Clinics/Separate Billings for Services and Supplies.
4. Separately Billed Prescribed Drugs.

States must divide their claims population into at least two strata, one of which must be comprised of all claims types not included in the other strata. Claims should be stratified by dollar amount; i.e., high dollar claims in one strata, low dollar claims in the other.

D. Sampling Frames.—The sampling frames for the prescribed sample universe are all Medicaid line items authorized for payment. This universe of line items may contain line items which relate to non-Medicaid programs. Exclude these line items from the

sample results. This may be accomplished by dropping the review of the non-Medicaid line items or by removing these line items from the sampling frame prior to sampling. If line items are removed from the sampling frame based on specific State provider or service codes, take care to ensure that ALL line items bearing that coded designation are not in the population of interest.

Where there is any doubt about the exclusion of a specific code, leave it in the sampling frame, and drop inappropriately sampled line items during the review process.

The line item universe is stratified prior to sampling, and stratification may be based solely on the type of provider which submits the bill. For example, a line item for a lab fee billed by an inpatient hospital is sampled in the inpatient hospital stratum. A lab fee billed by an independent lab is included in the other individual practitioner's stratum. States for which the prescribed strata are inefficient or involve sampling hardships may restructure the strata to suit the State's needs. The criteria the proposed alternative stratification must meet are a minimum of two strata structured to group homogeneous line item payment amounts and a satisfactory stratification rationale is given in the sampling plan. The specific line item provider type strata are defined to be the following. The number following the provider type description is the CFR reference.

E. Provider Type Strata.

100 Series - Hospital Services:

101. Billings for Inpatient Hospital Services Other Than Services for TB or Mental Diseases-440.10.

200 Series - Long-Term Care Services

201. Skilled nursing facility for individuals age 21 or older other than services in an institution for TB or mental diseases-440.40(a);

202. inpatient hospital services for individuals age 65 or older in institutions for TB or mental diseases-440.140(a);

203. skilled nursing facility services for individuals age 65 or older in institution for TB or mental diseases-440.140(b);

204. intermediate care facility services for individuals age 65 or older in institutions for TB or mental diseases-440.140(c);

205. intermediate care facility services other than in an institution for TB or mental diseases-440.150;

206. inpatient psychiatric services for individuals under age 21-440.160;

207. services in Christian Science sanatoriums-440.170(c);

208. skilled nursing facility services for individuals under age 21-440.170(d); and

209. services furnished during the month admitted to a public institution or an institution for TB or mental diseases-435.1008(b).

300 Series - Other Individual Practitioners, Clinics/Separate Services and Supplies:

301. Outpatient hospital services-440.20(a);

302. rural health clinic services-440.20(b);

303. physicians' services-440.50;

304. medical or other remedial care provided by licensed practitioners-440.60;

305. clinic services-440.90;

306. EPSDT-440.40(b);

307. other laboratory and X-ray services-440.30;

308. home health services-440.70;

309. private duty nursing services 440.80;

310. dentures, prosthetic devices, and eyeglasses-440.120(b), (c), and (d);

311. diagnostic services-440.130(a);

312. screening services-440.130(b);

313. preventive services-440.130(c);

314. rehabilitation services-440.130(d);

315. transportation-440.170(a);

316. services of Christian Science nurses-440.170(b);

317. personal care services in a recipient's home-440.170(f);

318. PT, OT, and other individual services-440.110;

319. dental services-440.100;

320. emergency hospital services-440.170(e); and

321. other care-440.170.

400 Series - Prescribed Drugs:

401. Separately Billed Prescribed Drugs-440.120(a).

The above strata are consistent with the reporting strata for the HCFA-120 report. The correspondence between the above strata and the HCFA-120 service type codes in the appendix of the report instructions are:

1. Inpatient hospital - HCFA-120 service type 1;
2. long-term care - HCFA-120 service types 2 through 7;
3. other - HCFA-120 service types 8 through 15 and 17 through 20; and
4. prescribed drugs - HCFA-120 service type 16.

It is assumed that for those States stratifying by provider type most States will choose to partition the line item universe into provider type strata based on provider type codes contained in the line item records. Where this is done, the State must document that the provider type codes on the sampling frame records accurately reflect the correct provider stratum. To demonstrate this, the State must conduct a sample study the first time a sampling frame is used, and submit summarized results to the HCFA RO for review. To demonstrate the accuracy of the provider codes the State must select a random sample of 750 line items authorized for payment from the total authorized line item file. For each line item the State must match the provider type code on the authorized line item file to the provider type on the original source document; e.g., hard copy, tape to tape facsimile. In order for States to use the provider type codes in partitioning the sampling frame, 735 of the 750 sample line items must be coded within the proper stratum. For States which fail to meet this tolerance, the HCFA-RO in consultation with HCFA-CO will negotiate with the State to determine an acceptable sampling plan.

F. Summary of Line Items Excluded From the Sample.—The line item CP QC sample is restricted to the universe of Medicaid line items authorized for payment. Examples of line items excluded from the sampling frame are:

1. Line items authorized for payment by non-Medicaid or nonmatched programs; e.g., payments for individuals eligible only for programs fully funded by the State;

2. non-Medicaid payments for noncovered services;

3. payments for 100 percent federally funded programs; and

4. end-of-year institutional cost settlements.

G. Sample Selection.—Systematic or simple random sampling is recommended for selection of the CP QC sample. The individual stratum line item samples are selected from the stratified sampling frames. It may be advantageous to the State to use different sampling methodologies in the various strata. This is acceptable provided that the methodologies are clearly outlined in the sampling plan for each stratum.

Sample selection must be performed on a complete sampling frame. It is essential that all updates to the line item files for the sample month are incorporated to ensure inclusion in the sampling frame of all line items authorized for payment in the State's specified sample month. Sampling may be conducted on complete lists at the end of the sample month or during the month as CP runs are made.

The State must submit a list of all sampled line items to the HCFA-RO prior to the assignment of those line items to review staff. This list must include all sampled items,

their claims identification numbers, their State-specified QC review numbers, and the authorized payment amount. For sampled adjustments, the listed amount may be either the gross or net amount of the adjustment. However, the net amount is subjected to review.

11608.1 Requirements for Sampling Plan Documentation.--Each State's CP QC sample must be selected in accordance with a sampling plan approved by the HCFA-RO. This sampling plan is separate from that submitted for the eligibility case sample. Before implementation of a sampling methodology the State must submit for HCFA-RO approval specific documentation of the sampling plan to be employed. It must describe each of the following proposed sample characteristics:

1. The universe of line items to be sampled;
2. the list(s) from which the sample is selected;
3. the sample sizes; and
4. the sample selection procedures.

Each of the above characteristics must be described in detail for each stratum in the line item sample. Declarations of compliance with sections of this manual in the sampling plan are not acceptable.

Any proposed revisions to the sample design must be documented in a revised sampling plan. The revised plan must be submitted to the HCFA-RO for review and approval prior to its implementation. Approved sampling plans remain in effect for the entire 6-month period unless circumstances beyond the State's QC unit control make this impossible. Any such situation must be documented by the State and the necessary changes approved by both the HCFA-RO and HCFA-CO.

Basic sampling plans must be submitted to the HCFA-RO 60 days prior to the corresponding review period. Detailed universe estimates and sampling intervals must be submitted at least 2 weeks prior to the first sample selection of the period. States must submit a basic sampling plan only when a revision to the most recent approved plan is proposed. Detailed universe estimates and interval calculations must be resubmitted for each sample period. The HCFA-RO determines the adequacy of the sample size. The claims processing and eligibility sampling plans are reviewed and approved by the HCFA-RO independently of each other.

A. Line Item Universe To Be Sampled.—The sampling plan must describe in detail the lists from which the CP QC sample is selected. It is expected that the sampling

frame lists will be partitioned subsets of the file of all line items authorized for payment. The sampling frame lists for line items may consist of a subset from a processed line item list or any other appropriate source. Regardless of the source of each sampling frame, the sampling plan must explicitly describe the following characteristics of the sample selection lists for each line item stratum:

1. Source;

2. the types of line items on the lists;

3. the accuracy and completeness of the lists in regard to the particular stratum;

4. whether the list is complete or is formed by merging a number of lists;

5. the physical form of the lists (e.g., computerized master file, local computer files, hard copy);

6. the frequency of and length of delay in updating the sample frame lists of line items;

7. the number of line items authorized for payment on the lists and an estimate of the proportion of listed-in-error items;

8. methods used to delete unwanted items from the lists; and

9. whether the lists are made up of line items or invoices and the method employed to create a line item list, if applicable.

States are permitted to specify a sample month other than the calendar month if their recording and payment procedures operate on another fixed monthly cycle. This sample month must be specified in the sampling plan and can vary by no more than 15 days from the calendar month. It must be documented that this revised sample month is based on an existing State reporting or processing cycle. A desire to begin sample reviews at an earlier date is not an acceptable justification.

B. Sample Size.—The basic sample sizes (i.e., the minimum number of reviews to be completed) for the 6-month review period are specified in appendix B for each State. States may reallocate the required total sample size among strata based on desired areas of concentration. The plan must specify for each stratum and substratum the expected number of claims selected, listed in error, and completed, and must include a justification of non-prescribed sample sizes or allocations.

States with exceptionally small universes may request a reduction in the minimum required sample size due to the effect of the Finite Population Correction (FPC) factor. This request must include documentation of universe estimates by stratum. The final decision on reducing a required minimum sample size will be made by HCFA-CO based on a verification of the FPC effect.

C. Sample Selection Procedures.—The procedures used in selecting the sample line items must be described in detail in the sampling plan for each (sub)stratum. These procedures must conform to the guidelines and procedures in §11608.2. If the sampling frame for a stratum is comprised of more than one list, the sampling methodology for each list must be defined. Different sampling methodologies may be used in different strata providing they are all documented properly and approved by HCFA-CO.

Alternative sampling plans which provide a valid statistical sample will be considered for approval. The major criteria that nonprescribed methodologies must meet is that the methodology provides precision of estimates equivalent to a simple random sample. The variance equivalence which must be demonstrated applies to the payment CP error rate across all strata. The variance equivalence of a nonstandard methodology must be demonstrated in the sampling plan submittal.

Although it is recognized that the prescribed systematic sample is technically a cluster sample with a potentially larger variance than a random sample, the increase in variance is in standard practice assumed to be negligible. The benefit of any alternative sampling method should be to gain information or to make sampling more practical. Therefore, the intent of the variance equivalence requirement is to preclude the acceptance of alternate sampling plans which produce unreliable estimates.

11608.2 Selection of Systematic and Simple Random Samples.—It is recommended that States use either systematic or simple random sampling for selecting sample line items from the stratum sampling frames. Systematic sampling is the preferred method for CP QC purposes. It provides a pattern of selection of individual line items from the sampling frame list at equally spaced intervals, with the starting point being determined by random selection.

A systematic sample is self-weighting across months if the same sampling interval is used throughout a review period. It is important that line items with similar probabilities of error are not placed at equally spaced intervals. Otherwise, a systematic sample will not yield a truly random sample. The pattern of line items on the sampling frame list must be random with respect to error likelihood.

Simple random sampling, or other more complex sampling methodologies, will in most cases be more difficult to administer than a systematic sample. In simple random

sampling each line item on the sample selection list is assigned a unique identifying number. Numbers are then selected by some random process and the corresponding line item on the sampling frame list included in the sample.

The following steps in sections A and B describe the steps involved in selecting a systematic line item sample. These steps are applied independently to the sampling frame lists for each (sub)stratum. Note that the steps in section A relate to calculation of a sampling interval and are performed only at the beginning of each period. The steps in section B outline the sample selection procedures for authorized line items and are performed monthly.

A. Calculation of the Sampling Interval.—Employ the following steps to calculate the systematic sampling interval at the beginning of each period. This step sequence is followed separately for each (sub)stratum.

Step A - Estimate the Average Monthly Sample Frame Size

The average monthly sample frame size is an estimate of the average number of line items contained on the list which is subject to sampling during each month of the 6-month review period. The monthly sampling frame size may be expected to vary. In estimating the average monthly sampling frame size, consider any known circumstances, such as policy changes, that would appreciably affect the size.

Step B - Determine the Number of Required Completed Line Item Reviews

Appendix B contains the minimum number of completed reviews required for each 6-month review period. If a State wishes, it may increase the number of completed reviews.

Step C - Estimate the Average Number of Reviews To Be Completed Monthly

The average number of reviews to be completed monthly is calculated by dividing the number of required completed line item reviews for the 6-month review period (step B) by six.

Step D - Estimate the Proportion of Line Items Listed in Error

Listed-in-error line items are line items included in the sample selection list which are not in the population of interest (e.g., line items for totally State-funded programs). The estimate reflects the true proportion for the entire 6-month period.

Step E - Calculate the sampling interval using the following formula where:

X - average monthly sample frame size (step A);

Y - average number of reviews to be completed monthly (step C);

Z - proportion of line items listed in error (step D);
sampling interval (I) = X x (1-Z) /Y.

Unless a correction for undersampling or excessive oversampling is necessary (refer to §11608.3), the same sampling interval must be applied in each month of the 6-month review period. This sampling interval is always rounded down to the next lower integer (e.g., 25.67 becomes 25).

As an example assume that:

1. The average monthly sample frame size (X) is 11,000;

2. the average number of reviews to be completed monthly (Y) is 100; and

3. the proportion of line items listed in error (Z) is 5/100 (or .05).

The sampling interval (I) is:

I = 11,000 X .95/100 = 104.5;
rounded down to 104.

The number of line items selected for a review month must exceed the number of sample line items required in order to compensate for dropped reviews due to selected line items which are not in the population of interest (listed in error). The sample of line items reviewed includes only the line items selected that are in the population of interest.

B. Selection of Line Items for the Review Month.—The selection of line items for the review month consists of three steps. These are repeated for each month of the review period using the same sampling interval. These steps are performed independently for each (sub)stratum.

Step F - Make Any Necessary Adjustment in the Sampling Interval for Undersampling or Excessive Oversampling

Undersampling (or excessive oversampling) exists when the actual number of completed line item reviews is below (or significantly above) the required number. Undersampling must be corrected to achieve the minimum sample size. Excessive oversampling may be reduced at State option so that actual sample sizes will be closer to the minimum required sample sizes. Detailed procedures for correction are in §11608.3. The new sampling interval calculated as part of these procedures is used in selecting sample line items for the review month.

Step G - Select a Random Start

The random start, j, is an integer between one and the sampling interval, I, inclusive. This number is selected randomly (usually using a table of random numbers).

Step H - Select Sample Line Items

The first line item selected is the j'th line item (random start number) on the sample selection list. Every I'th (sampling interval) entry following the j'th line item on the sample selection list is chosen as part of the monthly sample. Thus, if the random start is 28 and the sampling interval is 104, the 28'th, 132'nd, 236'th, 340'th, etc., entries on the sample selection list are selected for the sample. (Note that only the line items selected must be reviewed in the sample. If line item 132 is selected, reviewing line item 131 or 133 is not acceptable.) The process of selection continues in this fashion until the end of the list is reached.

11608.3 Procedures for Correcting the Monthly Sample for Excessive Oversampling and Undersampling.—Note that undersampling (completion of fewer line items than required) must be corrected using the procedures outlined. Correcting for oversampling is a State option. Alternative methods, most of which will result in excessively stratified estimates, must be approved by both the HCFA regional and central offices. Adoption of even the prescribed procedures must be approved by the HCFA RO prior to implementation. The correction procedures adopted must be applied independently to the over/undersampled stratum/substratum.

A. Correcting for Excessive Oversampling.—Oversampling is a normal part of the sampling operation which compensates for unidentifiable but anticipated "not reviewed" line items. However, the State may find that it has oversampled more than necessary. This can be due to such factors as a larger allowance made for anticipated "not reviewed" line items than were found, or to an underestimated line item universe size for the reporting period resulting in the use of a smaller than necessary sampling interval.

If a State wishes to reduce this sample, the recommended method to correct for oversampling to produce unbiased estimates without resorting to complex weighting procedures is:

1. Using the methods described in §11608.2 A, recompute the sampling interval for the reporting period using revised estimates of the sample frame size and/or the fraction of reviews to be dropped.

For each month in which sample line items have already been selected:

2. Compute a revised estimate of the number of sample line items which should have been selected in the preceding months of the sampling period as follows:

Revised estimate of the number of sample line items for the month = (Monthly Sample) Selection List Size/Revised Sampling Interval

3. Subtract the number of line items obtained in step 2 from the number of sample line items that have been selected. This is the number of line items to be eliminated (regardless of whether the review has been initiated or not).

4. Divide the number of sample line items that have already been selected by the number of line items to be eliminated (obtained in step 3) to obtain the secondary sampling interval to be used in identifying the specific line items to be eliminated.

5. Use a random start and apply the secondary sampling interval obtained in step 4 to select line items from the list of sample line items already selected. Eliminate the line items identified.

For months for which sample line items have not yet been selected:

6. Use the corrected sampling interval for the reporting period obtained in step 1 to select sample line items from the monthly frames.

B. Correcting for Undersampling.—Undersampling generally occurs if the number of "not reviewed" line items is greater than expected or the estimate of the line item universe for the reporting period is too high. When such misestimation occurs, a larger sampling interval than appropriate is used, resulting in a sample which does not meet minimum requirements.

The recommended method for correcting undersampling in order to produce unbiased estimates without resorting to complex weighting procedures is:

1. Using the methods described in §11608.3A, recompute the correct sampling interval for the entire reporting period using revised estimates of the sample frame size and/or the fraction of reviews to be dropped.

For each month in which sample line items have already been selected:

2. Compute a revised estimate of the number of sample line items which should have been selected in the month as follows:

Revised estimate of the number of sample line items for the month = Monthly Sample Selection List Size/Revised Sampling Interval

3. Subtract the number of line items that have already been selected from the number obtained in step 2. This is the number of additional line items to be selected from the monthly frame.

4. Divide the total monthly sampling frame size by the number identified in step 3 to obtain the secondary sampling interval to be used in identifying the additional line items to be selected from the monthly sampling frame.

5. Use a random start and apply the secondary sampling interval calculated in step 4 to the monthly sampling frame from which line items have already been selected. Add the specific line items identified to the line items selected and reviewed for the same month as the month of the sampling frame from which it was selected. (If a line item that has been previously selected in the sample is identified, select an alternate line item by using a table of random numbers.) This procedure oversamples for line items that are listed in error. Discard line items that are selected which are listed in error.

For months for which sample line items have not yet been selected:

6. Use the corrected sampling interval for the reporting period obtained in step 1 to select sample line items from the monthly frames.

C. Guidelines for Expanded and Substratified Samples.--A State may choose to modify the basic sample requirements by expanding the size of the sample (i.e., increasing the number of line items to be reviewed) or by further dividing the sample into strata representing homogeneous subgroups of the population at interest. Note that the basic CP QC sample design for the line item sample is already stratified. The following sections presents guidelines that a State must use if it chooses to substratify the CP QC sample.

D. Guidelines for Expanding the Sample Size.--States may choose to increase the number of completed reviews beyond the minimum numbers specified; however, the following guidelines must be adhered to:

1. If additional line items are selected across the entire spectrum of one of the State CP QC strata in accordance with the State sampling plan, the additional line items are to be considered as part of the CP QC sample. All reports submitted are to include these line items and associated review information.

2. If the additional line items come only from a particular segment of one of the populations (e.g., a specific provider or specific counties) they may, at State option, not be considered as part of the CP QC sample and may be excluded from reports to HCFA-CO. However, the sampling plan submitted to the HCFA-RO must identify this segment of line items and when the sample from the segment is selected, appropriate controls must be applied to separate those line items from the rest of the line items included in the CP QC process. If these line items are included in reports to HCFA, they must be weighted in accordance with the rules specified by HCFA. If these additional line items are selected with a different sampling methodology, they are to be excluded from reports to HCFA.

Note that any planned expansions in the sample size must be explained in detail in the sampling plan documentation submitted to HCFA-RO for approval.

E. Guidelines for Further Stratifications.—The basic CP QC sample design suggests that the Medicaid population in a State be sampled in groups stratified as follows:

1. CP QC sample strata:

   a. - inpatient hospital;

   b. - long-term care;

   c. - other individual practitioners, clinics/services, and supplies; and

   d. - drugs.

A State may choose to further stratify into substrata. The State is encouraged to substratify the sample to best suit the State's needs. For example, a State may divide its inpatient hospital strata into drugs and other. Other beneficial stratification may include specific geographic breakdowns of providers.

In substratifying the sample, a State must comply with the following:

1. There can be no more than three substrata in each stratum; and

2. there cannot be fewer than 50 completed line item reviews per substratum for the 6-month review period.

11609. DOCUMENTATION SOURCE SHEET

A documentation source sheet is optional but recommended for all errors recorded. This sheet provides for the recording of information related to procedural errors, development, and whether procedural errors found resulted in a dollar error.

A. Nature Code.—Nature error code is the applicable code(s) selected from the Error Category Profile. More than one error code may be entered on the documentation source sheet.

B. Support Document.—The descriptive title of each supporting document should be entered in this data element. If more than one support document is required to substantiate the error code entered, each support document should be entered on a separate line. The following are examples of supporting documents:

1. Recipient Eligibility Listing
2. Provider Eligibility Listing
3. Procedure Fee Schedule
4. Prior Authorization Form
5. Exception Processing Log
6. Provider Billing Manual
7. Manual Citation

C. Document Location.—This data element should contain the name of the agency which is custodian of the document as well as the document's physical location. The location should include any specific retrieval file, page, or other reference number.

D. Effective Date.—Provide the date that identifies the supporting document's applicability to the adjudication process.

E. Remarks.—Enter explanatory notes that support the error cited.

11-6-48

CP DOCUMENTATION

SOURCE SHEET

Page____of_____

State Code_____

Review N_____

Claim N_____

ERROR CODE	SUPPORT DOCUMENT	DOCUMENT LOCATION	EFFECTIVE DATE	REMARKS

Rev. 6

11610. CONTENTS OF THE STATE CPAS FILE

The State must supply or make available all the information and documentation necessary to conduct the Federal re-review of State CP findings. Each completed State review file should contain the following documentation:

1. Documentation of the claims payment authorization amount;
2. a copy of the provider invoice or provider invoice information;
3. provider certification documentation;
4. recipient eligibility certification documentation;
5. paid claim history information pertinent to the review findings;
6. documentation of any required medical judgment certifications;
7. a documentation source sheet if utilized;
8. permissible State practice references which bear on the review findings and which the reviewer deems necessary for clarification;
9. CPAS Review Schedule; and
10. explanation and documentation required to support review findings.

In addition, the State must have, or have available:

11. Certified provider listing and recipient eligibility files;
12. permissible State practice which defines allowed services, frequency limitations, and any other pertinent program requirements;
13. fee schedules, reimbursement tables, and other information on allowable payments to groups and individual providers; and
14. listing of covered services.

11611. CPAS CORRECTIVE ACTION

CPAS corrective action (CA) involves a full range of State initiated activities designed to eliminate errors in State claims processing and misspent Federal funds resulting from these errors.

All State agencies are required to submit a comprehensive corrective action plan to the HCFA-RO which provides an analysis of CPAS findings and detail State efforts to remedy deficiencies discovered in its claims processing. Each plan must address CP errors discovered subsequent to the period covered by the previous corrective action plan. The plan is to be submitted to the HCFA-RO by August 31 of each year as a part of the State's annual CPAS report.

The State agency must prepare the CA plan in three major steps.

A. Identification of Errors and Causes.—This section summarizes State CPAS data and analyzes the major concentrations of errors. It also reports the results of any special studies used to obtain additional information on the identification of errors and related causes. Finally it includes a statement of the cause of each major concentration of errors.

B. Planned Corrective Action.—Section two details CA planned or implemented. This includes a description of CA selected for each identified cause of error and the overall implementation schedule for each action showing the major task to be conducted. In addition, list the specific dates for the completion of key tasks, along with all tasks and milestones for all affected agency and administrative components. Identify all anticipated results, costs, and time schedule of the CA.

C. Evaluation of Results of Planned CA Previously Reported.—This section describes the proposed method of evaluating the CA effectiveness and source and method of evaluation and assembling data.

STATE CODES

ALABAMA	AL	01
ALASKA	AK	02
ARIZONA	AZ	04
ARKANSAS	AR	05
CALIFORNIA	CA	06
COLORADO	CO	08
CONNECTICUT	CT	09
DELAWARE	DE	10
DIST. OF COLUMBIA	DC	11
FLORIDA	FL	12
GEORGIA	GA	13
HAWAII	HI	15
IDAHO	ID	16
ILLINOIS	IL	17
INDIANA	IN	18
IOWA	IA	19
KANSAS	KS	20
KENTUCKY	KY	21
LOUISIANA	LA	22
MAINE	ME	23
MARYLAND	MD	24
MASSACHUSETTS	MA	25
MICHIGAN	MI	26
MINNESOTA	MN	27
MISSISSIPPI	MS	28
MISSOURI	MO	29
MONTANA	MT	30
NEBRASKA	NE	31
NEVADA	NV	32
NEW HAMPSHIRE	NH	33
NEW JERSEY	NJ	34
NEW MEXICO	NM	35
NEW YORK	NY	36
NORTH CAROLINA	NC	37
NORTH DAKOTA	ND	38
OHIO	OH	39
OKLAHOMA	OK	40
OREGON	OR	41
PENNSYLVANIA	PA	42
PUERTO RICO	PR	72
RHODE ISLAND	RI	44
SOUTH CAROLINA	SC	45
SOUTH DAKOTA	SD	46
TENNESSEE	TN	47
TEXAS	TX	48
UTAH	UT	49
VERMONT	VT	50
VIRGINIA	VA	51
VIRGIN ISLANDS	VI	78
WASHINGTON	WA	53
WEST VIRGINIA	WV	54
WISCONSIN	WI	55
WYOMING	WY	56
GUAM	GU	66

ANNUAL SAMPLE SIZES
(USE 1/2 for 6-Month Period.)

Region I	
Connecticut	6,000
Maine	4,200
Massachusetts	10,400
New Hampshire	2,600
Rhode Island	4,200
Vermont	2,600
Region II	
New Jersey	10,400
New York	10,400
Puerto Rico	4,200
Virgin Islands	2,600
Region III	
Delaware	2,600
District of Columbia	4,200
Maryland	8,100
Pennsylvania	10,400
Virginia	8,100
West Virginia	4,200
Region IV	
Alabama	6,000
Florida	8,100
Georgia	8,100
Kentucky	6,000
Mississippi	4,200
North Carolina	8,100
South Carolina	6,000
Tennessee	8,100
Region V	
Illinois	10,400
Indiana	8,100
Michigan	10,400
Minnesota	8,100
Ohio	10,400
Wisconsin	10,400

ANNUAL SAMPLE SIZES
(USE 1/2 for 6-Month Period.)

Region VI	
Arkansas	6,000
Louisiana	8,100
New Mexico	4,200
Oklahoma	6,000
Texas	10,400
Region VII	
Iowa	6,000
Kansas	6,000
Missouri	6,000
Nebraska	4,200
Region VIII	
Colorado	4,200
Montana	2,600
North Dakota	2,600
South Dakota	2,600
Utah	2,600
Wyoming	2,600
Region IX	
Arizona	-----
California	10,400
Guam	2,600
Hawaii	4,200
Nevada	2,600
Region X	
Alaska	2,600
Idaho	2,600
Oregon	6,000
Washington	8,100

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